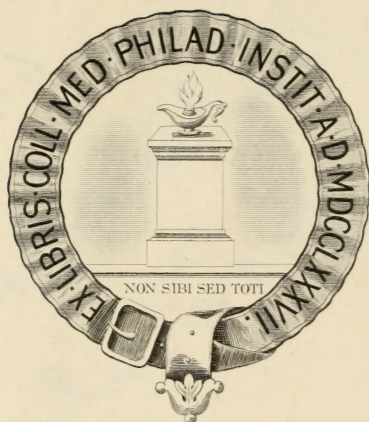




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The HAHNEMANNIAN Monthly.

(VOLUME THIRTY-FIFTH.)

JANUARY TO DECEMBER,
1900.

EDITED BY
WM. W. VAN BAUN, M.D.

PHILADELPHIA:
1900.

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THE HAHNEMANNIAN MONTHLY.

JANUARY, 1900.

THE PRESENT STATUS OF THE SURGICAL TREATMENT OF SALPINGITIS.

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(Read before the Massachusetts Homœopathic Medical Society, October, 1899.)

CONSERVATISM rather than radicalism is the keynote of modern gynæcology, and nowhere has this principle been more emphasized than in the treatment of salpingitis. The mere presence of this disease is not an indication for operation. Many acute cases undergo resolution and cure with appropriate treatment. This is especially true when the tube is distended by non-septic material, and the writer has seen recovery even in severe cases following gonorrhœa. These facts warrant delay in operating for acute salpingitis unless urgent symptoms are present. Pyosalpinx, pus in the Fallopian tube, very often requires surgical aid, and the problem is not so much how to remove the pus, but rather how to treat the case with the least mutilation of the patient.

Bacteria and their toxins are the cause of suppuration, and the abscess grows only when they are present.* With the death of the bacteria the production of toxin ceases. The pus becomes sterile, and we have water, leucocytes, and a little degenerated tissue surrounded by the protecting zone of

* Ziegler, *General Pathology*, p. 300, 1893.

small cell infiltration, which has compressed somewhat the blood and lymphatic vessels, so that resolution and repair proceed slowly. The immediate examination of the contents of the tube before closing the abdomen was undertaken at Johns Hopkins for the purpose of determining the necessity of drainage of the peritonæum, and elsewhere for scientific purposes. Pathogenetic, *i.e.*, virulent, bacteria are rarely present,* and further investigation has shown that, with few exceptions, the bacteria in the pus of a pyosalpinx disappear in a few months; some believe in three months; others give an average of nine months from the formation to the sterility of the pus.† Bacteria confined encapsuled in closed cavities soon lose their virulence and die from their own products—the toxins. This explains why there is considerably less danger in operating on chronic than on acute cases. This important clinical fact has done much to limit a drainage which seldom drains and often provides a path for infection. It has led indirectly to the dry method of operating with sterile packing about the field of operation with sterile gauze in the Trendelenberg position, and, if necessary, completing the peritoneal toilette with copious flushing with sterile salt-solution, and drainage through the lymphatics by Clark's method rather than by ordinary drainage.

The impunity with which very considerable collections of pus in the tubes can be treated has led to various attempts at surgical repair without removal of the tubes, which has been lightly termed gynæcological millinery; but, in spite of such pleasantries, it is more than possible that such conservative surgery, aided by the microscope and bacteriological diagnosis, may yet open a new field for the gynæcologist. If the contents of the tube are known to be sterile, why is it not logical to empty the tube, irrigate it, and close the incision with a Lembert suture? or, if the organic changes are very pronounced at the outer extremity of the tube, to resect it, and unite the mucosa and peritonæum so as to make a new orifice and preserve the ovary whenever possible, though suspension of the latter may be necessary?

This already has been attempted with some degree of suc-

* Gebhard, *Pathologische Anatomie*, p. 442, 1899.

† Kiefer, *Centralblatt für Gynäkologie*, No. 42, 1896.

cess,* but the extensive pathological changes usually present have led most surgeons to believe that such an effort to obtain repair is useless, and a waste of time. As a matter of fact, the ultimate results of conservatism of this kind have shown many failures, and the necessity for a second operation. Until better results are obtained, drainage of a pyosalpinx and conservation of the tube is liable to require a second operation.

The treatment of a comparatively healthy tube and ovary on the opposite side is still disputed, as experience has shown that many such cases require a subsequent operation if both tubes and ovaries are not removed; but with a better knowledge of the ætiology of salpingitis, there is an increasing tendency to leave the second tube and ovary, and take more pains with the disinfection of the vagina and the uterine cavity.

The question of choice between the ventral or vaginal method occupies debatable ground, which is not fully covered by allowing the conditions present to determine the choice of operation. In a general way, it may be said that when these conditions absolutely preclude all attempts to preserve intact some part of the tube or ovary the vaginal operation is in order, as when there is bilateral salpingitis and ovaritis.

The advantages of the radical vaginal operation have been fairly stated,† as follows:

1. The patient consents more willingly to the operation.
2. It is possible to remove at the same time the smaller and harmless new growths without waiting until the growths become unbearable on account of their dimensions, or until inflammatory adhesions, suppuration, or malignant degeneration occur.
3. Diminished chances of infection.
4. The possibility of operating under less favorable conditions.
5. Diminished mechanical irritation of the intestines and parietal peritonæum by the hands of the operator and his assistants, sponges, instruments, sheets, etc., which come in direct contact with the peritoneal cavity.

* Dudley, *American Gynecological and Obstetrical Journal*, February, 1897. Dudley, *American Gynecological and Obstetrical Journal*, October, 1898. Dudley, *American Journal of Obstetrics*, vol. xxxviii., No. 1, 1898.

† *Deutsche Medizinical Zeitung*, August 10, 1899.

6. Diminished danger in cases of flow of the purulent contents from the torn sac of the new growth.

7. More satisfactory post-operative course of the case and speedy convalescence.

8. Absence of danger of ventral hernia, and no need of an abdominal binder.

9. The possibility of doing bodily work soon after the operation.

10. Diminished mortality.

These advantages are fairly stated, and yet the one great disadvantage outweighs nearly all of them, *i.e.*, vaginal hysterectomy precludes conservative surgery. The ease and success with which this operation can be performed in a large number of cases makes this operation, *par excellence*, the temptation of skill, and no record will be published of the victims of such radical treatment.

The recent report of Schauta* is a powerful argument in favor of the vaginal method, and is markedly confirmatory of the earlier report of Landau; but it must be remembered that a large proportion of these abdominal operations were performed by older methods, which do not compare with the modern ones now used by progressive operators, and his statistics do not admit of accurate comparison with the more recent methods. His paper is chiefly valuable as it deals with the permanent results following operations. It is only fair to concede preference to that method which favors the lowest mortality with the largest percentage of permanent recoveries. Applying this principle to 549 cases, we have:

	Mortality. Per cent.	Permanent Recovery. Per cent.
Vaginal radical operation,	2.7	86.8
Abdominal radical operation,	10.5	81.00
Vaginal unilateral adnexa operation,	14.2	22.20
Abdominal unilateral adnexa operation, with extirpation of the uterus,	0.00	50.00
Abdominal bilateral adnexa operation,	6.90	59.80

This means that complete extirpation of both the uterus and the adnexa, preferably by the vagina, gives a lower mortality and a larger percentage of cures than any of the so-called con-

* *Archiv. für Gynäkologie*, Bd. lix., H. 1, 1899.

servative methods—a statement which would be open to some question in spite of the large number of cases reported, which may be summed up as follows :

	Method of Operation.	Number.	Cured.	Mortality, Per cent.
Abdominal.	Unilateral removal of the appendages,	20	19	5.00
	Bilateral removal of the appendages,	286	266	6.90
	Bilateral removal of the appendages, with extirpation of the uterus (abdominal radical operation),	38	34	10.50
	Total abdominal operations on the append- ages,	344	319	7.20
Vaginal.	Unilateral removal of the appendages,	21	18	14.20
	Unilateral removal of the appendages, with extirpation of the uterus,	7	7	0.00
	Bilateral removal of the appendages,	1	1	0.00
	Bilateral removal of the appendages, with extirpation of the uterus (vaginal radical operation),	220	214	2.70
	Total vaginal adnexa operations,	249	240	3.60

Max Landau* reported from Jacob's clinic, in Brussels, and other sources, 1626 laparotomies for chronic salpingitis, with a mortality of 5.59 per cent., including 140 of Schauta's cases, just reported, and he preferred the radical vaginal operation.

A more careful examination of this report shows that a considerable number of the cases were not purulent, and many were operated on before 1890. It is only fair to claim that with methods now used the rate of mortality (5.59 per cent.) would materially diminish, though Schauta reports 7.20 per cent. in 344 similar operations, nearly all of which were pus cases. It is only fair to state, by way of contrast, that Leopold Landau† reported soon after 141 cases of vaginal hysterectomy, with a mortality of 2.80 per cent., yet he could estimate only 60 to 70 per cent. of perfect recoveries, which is a different matter from recovery from the operation. This is the reason why many surgeons refuse to accept this operation as perfect. The mortality-rate was low, but not much more than half of the cases were really cured. A later report‡ from L. Landau's clinic of 200 cases of vaginal hysterectomy for purulent disease of the appendages, with a mortality of 4 per cent., showed

* *Archiv. für Gynäkologie*, vol. xlv., H. 1, p. 101, 1894.

† *Archiv. für Gynäkologie*, Bd. xlv., H. 3, p. 397, 1894.

‡ Mainzer, *Archiv. für Gynäkologie*, Bd. liv., H. 3, p. 421, 1897.

better ultimate recoveries; and many of the best German operators still endorse total vaginal hysterectomy as the operation of choice for pyosalpinx.*

The French method of bisecting the uterus is now universally known and practised, with minor modifications by individual operators. The clamp allows better drainage than the ligature, and is better adapted to those cases of extensive pelvic suppuration. Whether the angiotribe or the electric clamp will prove another step in advance remains to be seen. It is reasonable to believe that a method which is secure from hæmorrhage, and at the same time does away with both clamps and ligatures, will be a step in advance. Until there is much experience demonstrating their safety, the writer believes the surgeon will rest more easily with the knowledge that a reliable ligature constricts the divided arteries of his patient.

The treatment of large accumulations of pus by vaginal incision and drainage is better restricted to cases of pelvic abscess pointing in the vagina; and even here it is often far wiser to perform hysterectomy and be sure of securing adequate drainage.

The trend of professional opinion is again toward the abdominal method, for the simple reason that it gives the patient every possible chance for conservative surgery, and, at the same time, every opportunity for radical treatment as well. It also gives the operator a better chance to examine the condition of the appendix, which sometimes complicates a salpingitis of the right side. Salpingitis and appendicitis coexist more often than has been believed, and the question of the advisability of examining the appendix as a routine procedure in laparotomy is under serious consideration.

At the International Congress of Gynæcology and Obstetrics in Amsterdam last August,† Dr. Hartmann, of Paris, in his paper on "The Operative Treatment of Salpingitis," stated that he would absolutely reject the vaginal route for inflammations of the adnexa, save that posterior colpotomy was still

* P. Bröse, *Zeitschrift für Geburtshilfe und Gynäkologie*, vol. xli., H. 2, p. 175, 1899. Also Bliessener, *Monatsschrift für Geburtshilfe u. Gynäkologie*, vols. iii. and iv., 1896. Also Cohn, *Archiv. für Gynäkologie*, vol. lix., H. 1, p. 24, 1899, and Dührsen, *ibid.*, vol. xlix.

† *New York Medical Record*, September 30, 1899.

indicated for large and easily accessible collections; this, moreover, in many cases, would have to be followed by a complete abdominal operation. Similar opinions were expressed by Faure and Duret.

No one set of rules can be or should be formulated for the treatment of suppurative salpingitis. The operator of to-day calls to aid the practical application of modern pathology and bacteriology and a broad knowledge of the work of his *confrères*. He wisely declines to follow any rule of thumb, and elects to be a law unto himself.

PERNICIOUS VOMITING OF PREGNANCY.

BY L. L. DANFORTH, M.D., NEW YORK CITY.

(Read before the American Institute of Homœopathy, Atlantic City, N. J., June, 1899.)

THERE is no disturbance of the health in early pregnancy so distressing or so difficult to relieve as the gastric irritability to which the term "pernicious" has been given by obstetric writers. Certain women are peculiarly sensitive to the reflex influences engendered by the gravid uterus, and early in pregnancy begin to suffer from nausea and vomiting, often to such a degree that they are finally unable to take and retain even the smallest quantity of the blandest nourishment.

As a result of this extreme gastric irritability the general health fails, the woman loses flesh, the eyes are sunken, the cheeks hollow, the tongue coated, the pulse rapid and weak, while the vomited matter often consists of bile and dark "coffee-ground" material from the stomach or intestines.

The physician in charge of a case of this kind will naturally inquire why it is that such a serious illness occurs in the course of what should be an uncomplicated physiological process.

We speak of "reflex vomiting" with a great deal of familiarity, but I am inclined to believe that there is, after all, very little knowledge on the subject which is exact and based on accurate scientific foundation. What do we mean when we say that the vomiting is reflex? Will the healthy gravid uterus

provoke an irritation in correlated nerves of other organs, and induce such a disturbance of function as is observed in these cases of pernicious vomiting? Or must there be some morbid condition of the uterus antecedent to and aggravated by pregnancy in order to cause this disorder? Again, is not the stomach itself primarily at fault, and has there not been some previous disease which makes this organ peculiarly liable to still greater derangement of function in sympathy with the changes in the uterus established by pregnancy? And, still further, is the influence of the gravid uterus exerted sympathetically upon the stomach directly and primarily, or is the brain the primary point of irritation, and the stomach derangement a secondary affection? These are all practical questions, and, if capable of being answered at all satisfactorily, the result cannot be otherwise than helpful in the treatment of these cases.

I shall attempt to answer these questions in the inverse order in which I have placed them.

First, with reference to the manner in which the uterus and stomach are correlated:

Is there a direct or an indirect relation between these two important organs? Some light may be thrown upon this question by reference to a communication made to the *British Medical Journal*, in October, 1887, by James Oliver, M.D., entitled the "Cause of Morning Sickness in Pregnancy." Dr. Oliver says: "Many theories have been adduced regarding the cause of morning sickness in pregnancy. All appear to have been speculative, and not one has met with anything like universal sufferance. Evolution may aid us in arriving at a just and feasible interpretation. From the earliest period of existence every organism has been endowed with two distinct qualifications: 1, that of maintaining self; 2, that of perpetuating species. At first the double function was performed by a uniform mass free from any semblance of structural differentiation. Habitual localization of function, however, produces eventually a specialization of structure, and with it the evolution of a new tract, whereby the interdependence is maintained. It is therefore feasible to suppose that the nerve centre which regulates the process of assimilation is either in apposition or at least in direct communication with that which presides over the organs of generation. All the visceral functions are now

performed automatically, and are regulated by nerve centres located in the medulla oblongata, the uterine, by inference, being no exception. Considering the close relationship that exists throughout life between the two processes of assimilation and reproduction, there can be no doubt that the representative nerve centres act and react upon each other. When the uterus becomes the nidus for a developing *germinal* mass, the molecular disturbances radiated therefrom to the reproductive centre are liable to be transmitted to the pneumogastric as well, and induce either a feeling of nausea or actual emesis. Usually, however, in the course of a few months, through habit, the pneumogastric centre becomes tolerant, and the symptoms evidencing disturbance at the same time disappear. It is difficult to understand why the sickness should be experienced more especially in the morning, unless it be that the change from the recumbent position to the erect posture after sleep renders the whole nervous system more liable to explosive disturbances. Frequently we find patients who only suffer from disturbances associated with epilepsy on assuming the erect posture after sleep. The more highly unstable the nervous system is generally, the more likely is a woman who becomes pregnant to suffer markedly and for a lengthened time from sickness, whether matutinal or more or less constant. It is well, however, to remember that the molecular radiations from the uterus itself may, for some reason or other, be materially augmented; and such, acting on a nervous system otherwise apparently healthy, may induce an aggravated turn of events."

Closely related to the line of reasoning followed by Dr. Oliver, and possibly dependent upon it, are the researches made by Prof. Tumas* on the subject of vomiting. Prof. Tumas finds that in dogs and cats section of the medulla at the level of the fourth ventricle does not prevent the *induction* of vomiting by hypodermic injections of apomorphia. By touching different parts of the medulla with a weak solution of apomorphia so as to induce vomiting, he was able to localize with tolerable precision the situation and extent of the vomiting centre, which he says lies in a space about 5 mm. in length by 2 mm. in breadth before and behind the calamus and in the deeper layers of the medulla.

* *Lancet*, October, 1887.

The researches of Prof. Tumas and the deductions of Dr. Oliver are interesting and instructive, and, if not wholly conclusive, certainly point by analogy toward the reproductive centre in the brain as the locality to which the irritative influence exerted by the gravid uterus is directed.

That the "vomiting centre" receives the impulse exerted upon it from the "reproductive centre" it is reasonable to believe, and the stomach, as the objective point of this irritation, responds accordingly, or perhaps in proportion to the susceptibility of the stomach itself.

On the one hand, therefore, the brain centre may be the most sensitive point, and, on the other, it is possible that the susceptibility lies in the organ to which the influence is directed. I think it fair to conclude that perturbed nerve influences and correlated functional disorders act and react upon each other. In one individual the special seat of aggravation may be situated in the uterus; in another the "vomiting centre" in the brain may be the hypersensitive area; while in a third the stomach itself may be the functionally depressed organ, and therefore the one most sympathetically affected. If, therefore, a just balance could be preserved between all organs, we should have no morbid tendencies to deal with; health would be the order of things in the human system.

According to this view, the ordinary morning sickness of pregnancy is always pathological and never physiological. If the above statements are well founded, we may now formulate a few principles which will suffice to answer the queries propounded in the beginning of this essay.

1. In the vomiting of pregnancy the stomach itself is not the primary point of attack when disturbed by those influences which we designate as reflex.

2. "Morning sickness" is not physiological, though when matutinal only and confined to one or two attacks each day it is not distinctly pathological, and indeed may be rather salutary than otherwise. The pathological is only a question of degree, and in its extreme form easily becomes *pernicious*.

3. Pernicious vomiting may have its origin in a variety of morbid conditions of special organs, or in a highly sensitive state of sympathetically related organs. There may be:

- (1) A congenital irritability of the nervous system that produces exaggerated response to normal reflex stimuli.

(2) Hyperæsthetic states of the spinal and sympathetic nerves of the uterus.

Under each of these heads may be mentioned the influence of sudden shocks or mental emotions, which are often exciting causes of local and general reflex irritability, and therefore predisposing causes of nausea and vomiting.

(3) Morbid conditions of the uterus, notably dislocations of the pregnant organ, whether congenital or acquired, or super-induced by pregnancy. Under this classification may be mentioned pathological conditions of the uterus, of the nature of tumors of the body of the uterus, chronic endometritis, and also diseases of the cervix uteri, whether affections of the glandular structures or of the muscular and connective-tissue elements. Cicatricial tissue, the result of former lacerations, doubtless favors nerve irritability, and delays the softening of the cervix, so essential to its normal development.

Preëxisting or coexisting pelvic disease, as a *salpingitis*, a *pyosalpinx*, or an *ovaritis*, are all capable of increasing to a high degree the tendency to hyperemesis by the influence they exert upon both local and remote nerve *ganglia*.

4. Pernicious vomiting is unquestionably more frequent in women who have previous to pregnancy been sufferers from pathologic states of the stomach, the liver, and the intestines.

Chronic gastric catarrh, associated with functional derangement of the liver (*lithæmia*) is certainly a predisposing factor in the causation of pernicious vomiting. Chronic constipation with *fecal toxæmia* also has a most deleterious influence upon the nervous system as well as upon the stomach, and is often a coexisting symptom of importance in connection with the ætiology and treatment of these cases.

5. Pernicious vomiting sometimes occasionally appears late in the course of pregnancy, and when of sudden development the death of the fœtus is one of the possible causes to be thought of. Another factor is *uræmic* poisoning; though this latter condition manifests itself by so many other symptoms, its influence could scarcely be overlooked or confounded with any other cause.

Symptoms.—In typical cases the ordinary morning sickness gradually increases in severity until there is an almost continuous retching and vomiting. Other cases are characterized by

great depression from the first; no food is retained, and, indeed, there is great loathing of food, the mere sight or smell of it being sufficient to cause retching. The patient cannot raise the head from the pillow, or even move an arm, without *emesis*; she grows extremely weak, and is subject to attacks of syncope. Emaciation progresses rapidly; the pulse is weak and rapid; the tongue dry, with a brown dry streak down the centre of it; the lips become fissured, and the teeth are covered with sordes. The skin has a sallow hue, and becomes harsh and dry; intestinal and gastric pains are common. Instead of dryness of the mouth we sometimes have profuse salivation, the patient incessantly spitting frothy or ropy saliva. I have seen patients who have spat a pint or more of ropy saliva in the course of twenty-four hours. Sometimes the thirst is great, and again there is entire absence of thirst.

Occasionally there is great restlessness and insomnia; the extremities become cold and clammy; the urine is scanty, highly colored, contains urates, and sometimes albumin and casts.

If this state of things continues the patient soon passes into an extremely dangerous condition. As regards the vomited matter, it is often green and bilious, and in extreme cases has the "coffee-ground" appearance, and sometimes is distinctly faecal in odor and appearance. A profound degree of exhaustion is the rule in these cases, and herein lies the danger; death will follow unless relief is quickly afforded.

Treatment.—The treatment of pernicious vomiting of pregnancy and its serious sequelæ affords the most brilliant testimony to the efficacy of drugs prescribed according to the law of similars, and, on the other hand, we must confess to some of the most dismal failures.

Assuming that the remedy has been selected with the greatest care, or, going still further, and admitting that the exact *similium* has been selected in a series of a dozen cases of hyperemesis in pregnancy, it is, I think, a fact which no truthful physician of experience will deny, that in a certain number the pernicious symptoms will go on unabated. In other words, the remedy has not done all that was expected of it. What is the reason for this discrepancy? Such an admission as this may appear to be a denial of the efficacy of the carefully

selected *similium*. Not at all! It is simply an admission that we sometimes expect too much from our medicines, and that other factors have to be taken into account beside the selection of the drug which is expected to cure. I would emphasize first, therefore, the importance of a careful scrutiny of all the concomitant conditions and symptoms which may be associated with those which are paramount, viz., those relating to the gastric irritability. Inquire first with reference to the digestive capacity of the patient before pregnancy; whether the functions of the bowels have been sufficiently and regularly performed, and also as to the quantity and quality of the urinary secretion. Renal insufficiency and fecal toxæmia from impaction may be unsuspected causes of blood and nerve empoisonment which must be eliminated before any remedy, no matter how well indicated, can have a satisfactory effect. Here would apply the various hygienic and sanitary regulations of functions, and the control of food and water, all of which are so essential to health. The state of the pelvic organs, especially the uterus, also must be most carefully investigated.

One of the worst cases of hyperemesis I ever saw went on from bad to worse until a retroverted uterus was put in place and kept there by a suitable support. I am very sure that some cases of hyperemesis are caused by diseased conditions of the cervix uteri. Old lacerations with cystic formations, and cicatricial tissue about the external as well as internal os, will aggravate, if not cause most intractable hyperemesis. When diseased conditions of the cervix exist, the *puncture of cysts*, the use of boro-glycerite tampons, and perhaps a careful dilatation of cicatricial bands at the internal os, will often prove highly beneficial in relieving some cases. Most physicians believe more or less in the doctrines of the "orificial philosophy," and it is safe to assert that the principles underlying this system may occasionally be applied with benefit to severe cases of vomiting in pregnancy.

Disease of the corporeal endometrium is often productive of abortion as well as hyperemesis. This condition cannot be treated during the existence of pregnancy, but it should be taken into consideration after the pregnancy is terminated, to prevent a recurrence of the malady in succeeding pregnancies.

There is, no doubt, much benefit to be gained by a careful

regulation of the diet, and the procurement of rest and freedom from mental worry. The mental state has much to do in the causation of hyperemesis with many women.

Hysteria is regarded as a cause by many writers. Emotional influences must be controlled, so far as possible.

But outside all these local and general causes, some of the worst cases we have to deal with are observed; cases in which no cause can be ascertained, and no extraneous influence is to be corrected. The patient simply vomits everything she takes into her stomach, and even retches when the stomach is empty if a hand is raised from the bed or the head from the pillow. Then, if the properly selected homœopathic remedy will not cure, nothing else will!

There are certain remedies I find more often indicated than others, and if given as they should be, the result will be satisfactory. Among these, the first in importance to be mentioned is *arsenicum*. This remedy corresponds more closely to pernicious vomiting than any other I know of. I am in the habit of giving it in the 200th attenuation, in water, every two hours. If the patient cannot retain even a teaspoonful of the liquid on the tongue, I then give just enough to wet the tongue, not enough to swallow, repeated at short intervals. If even this small amount is irritating, I medicate the smallest pellets (No. 10) with the 200th dilution and drop a few on the tongue every hour. I have seen the most aggravated cases improve on this remedy. Arsenic is often the remedy *par excellence*!

Bryonia 200th will prove very useful, even in the worst cases, when the patient vomits or retches every time she moves even one hand or turns in bed. The concomitant symptoms of bryonia are so well known that I need not repeat them.

Symphoro-carpus racemosa (the snow-berry) is useful in cases resembling the bryonia condition. The characteristic symptom of this remedy is this—"as long as the patient lies in bed, horizontal and perfectly quiet, she does not feel the desire to vomit." Repugnance to food or to the odor of it when being cooked. The remedy is especially useful in cases of *reflex* nausea. This remedy I have used with best effect in the 2d or 3d decimal trituration.

Phosphorus has recently relieved a most aggravated case, the patient complaining of vomiting of sour food, with burning at the pit of stomach, weakness in abdomen, etc.

As an example of what may be done with unusual remedies, one case of hyperemesis which had as its distinguishing symptom *profuse salivation*, with continued nausea and vomiting, was relieved by *jaborandi* 3x trit. The patient complained of a sense of goneness in the stomach and abdomen, and vomited as soon as she swallowed solids or liquids.

There is one point which I believe we do not sufficiently realize in the treatment of these cases, and that is *persistence* in the use of the remedy we believe to be the right one and then to give the smallest possible dose that will prove curative. In most of the cases of pernicious vomiting I have seen, the best results were attained with the higher potencies.

To enumerate many remedies would be taking too much time, but I would add that I have been greatly helped when the indicated remedy did not act by giving a dose of sulphur 200 as an intercurrent with the principal remedy. *Sulphur*, by the way, is often *the* remedy, and has done most excellent service in my hands.

I am furthermore of the opinion that if we had our cases from the beginning of pregnancy, and regulated the diet at the same time that we prescribed our remedies for moderate vomiting, there would be fewer cases of pernicious vomiting. While I am of the opinion that the properly selected homœopathic remedy will relieve pernicious vomiting, in the great majority of instances, if persisted in, I am also aware, from my observations in consultation practice, that there *are* cases which *do* go on to the extreme limit, even life being endangered by the severity of the symptoms and, presumably, after most careful homœopathic prescribing. Before we discuss the propriety of inducing abortion for the relief of the pernicious vomiting I would say a word about rectal feeding. It is often necessary to give the stomach *absolute* rest at least for a day or two, in order to relieve the extreme gastric irritability. In such cases rectal enemata of peptonized milk (5ij) and bovine (5i-ij) will be of great service; or we may use sarco-peptones or Moszuera's beef jelly (3ss of either) with water, 5iv, and, if the patient is very exhausted, one ounce of whisky may be added. These injections should be repeated not oftener than once in four hours—and the rectum should be washed out occasionally to secure cleanliness of the tract.

As regards the *induction* of abortion, I would state as indications for immediate interference the following symptoms: increasing diminution in the daily quantity of the urine, containing a variable amount of albumin; progressive emaciation; dry, coated tongue; frequent *small, thready* pulse, and a peculiar apathy of the patient. The pulse is of the most importance in making a decision; the smaller and more frequent the pulse the more serious the case. If the pulse is moderately strong and not especially rapid, delay is admissible. Coffee-ground vomit, or fæcal vomiting, is a bad sign.

When a case has gone as far as the above indications signify, it is time to act. Delay may mean the loss of the mother. If all known means have been faithfully tried, and the patient grows steadily worse, it is better to act than to delay until even action is dangerous.

When an operation has been decided upon, there is no use in wasting time by slow methods of emptying the uterus.

Anæsthetize the patient, secure absolute asepsis of genital tract and instruments, and then proceed with a strong steel dilator to open the uterine canal. The dilatation may be easy, or it may be very difficult. Be prepared for the difficult case. Thorough removal of the fœtus and secundines, followed by curettage and light uterine packing, is the proper procedure. To insure contraction, I often apply Churchill's compound tincture iodine to the endometrium, then douche and do not pack at all. Generally all symptoms subside, and the patient only has to recover from the weakness incident to her previous illness. A word of caution may be uttered with regard to the after-treatment. The patient should be left in charge of a trained nurse or competent physician at least during the twenty-four hours immediately following the operation. The real crisis frequently follows immediately in the wake of the operation, and unless promptly met and effectually combated all previous efforts will have been in vain.

One patient seen in consultation, with persisting vomiting of the most aggravated forms, died from exhaustion within twelve hours after an easy operation for emptying the uterus.

In closing, I would say that my aim has been, in discussing the treatment of pernicious vomiting, to emphasize the great superiority of homœopathic remedies over all others. The

paucity of my therapeutics is due to lack of time and space. Select the remedy by a careful individualization of symptoms, then give the minimum dose and adhere to it, meanwhile giving the stomach absolute rest by rectal feeding. If these means fail, empty the uterus, and do not delay so long that the patient will die from shock following what should be a perfectly safe procedure.

SURGICAL DRESSINGS.

BY HERBERT S. NICHOLS, M.D., PORTLAND, OREGON.

A WOUND is an incubator, or, if you please, a test tube filled with a nourishing pabulum, kept at an even temperature, a heat at which micro-organisms most readily thrive. The pabulum needs only inoculation, and the germ propagation goes vigorously on. Inoculation is first manifested by a slight redness, accompanied by some irritation or pain; then induration, a rise in temperature, finally suppuration and general systemic infection.

Fighting against these micro-organisms is the living cell in the wound, phagocytes, as they are called, and the modern germicidal dressing. It is the duty of the practitioner and surgeon, then, to cleanse a wound as far as possible from these pus-producing organisms, and apply a clean dressing which will prevent reinfection.

At the present time we have a large assortment of antiseptic dressings to choose from, and if we wish to obtain the best results in wound healing we must make an intelligent selection of the dressing to be used.

Dressings may be simply germicidal, or they may be germicidal and stimulating, or capable of removing unhealthy tissue. The skin of some patients may be very susceptible to an antiseptic, and another dressing must be substituted. A highly infected wound requires a hot, moist dressing of some powerful antiseptic solution, frequently changed, while a healthy, clean, uniting wound needs little more than an aseptic covering.

A simple antiseptic dressing may have no effect on a discharg-

ing sinus, while a very stimulating dressing will stop the discharge very quickly, and healthy granulations spring up at once. We should, therefore, observe the effect of all our dressings upon tissues, and, knowing how they will act, select a dressing for each kind of wound, just as we select a drug for each individual disease.

As a germicidal dressing, *bichloride of mercury* solution probably stands at the head of the list. Sternberg states that a one-to-40,000 solution will prevent the growth of germs. The solutions of 1-2000 and 1-4000 are in most common use, and it is well to know that a hot solution is much more effective than a lukewarm solution.

Bichloride of mercury has no other virtue than that of being a powerful antiseptic, but is for this purpose so much more effective than all other solutions, that it should be used for cleansing all traumatic wounds, and even those made by the surgeon's knife, as well as a dressing afterwards, unless there are contra-indications for its use. A hot bichloride dressing, changed every two hours, day and night, is one of the best means of controlling the inflammation of an infected part. In this way a sutured wound which shows redness, induration, and a corresponding rise in temperature, can frequently be made to heal by first intention. Sublimate solution has its contra-indications, however, and must often be substituted by another less toxic drug. In susceptible patients the toxic effects are manifest locally by a fine vesicular or pustular rash, with or without an erythematous condition of the skin; by constitutional symptoms, such as diarrhœa, nausea and salivation. I have in mind a case of breast amputation in which a 1-2000 solution was used only during the operation, and a dressing of wet bichloride gauze put on. The patient suffered with persistent nausea for two days, and on the third day the characteristic erosions about the teeth appeared. The patient improved rapidly under hepar sulphur and an alum mouth-wash.

The bichloride rash is a frequent and not at all alarming symptom; the erythema may, however, be taken for beginning infection, but a close watch of the temperature will differentiate between the two.

The dressings should be changed at once to carbolic acid or formalin, the entire surface having been previously washed with

soap and water. A dressing of soap and water for twenty-four hours has most excellent results in bad cases of bichloride poisoning.

Carbolic Acid Solution.—Though a much less powerful germicide, carbolic acid solution holds an important position among surgical dressings on account of its stimulating effects. For this reason it is one of the best dressings for open wounds which show no tendency to heal and may be covered with a grayish membrane. A 1-40 solution is the usual strength, but indolent wounds should be irrigated with a 1-20 solution, or $6\frac{1}{2}$ drachms to the pint of water. After two or three days of this dressing, red granulations spring up and the gray membrane is cast off. The entire wound may be cauterized with the pure acid, should the 1-20 solution not be effective. Boils, felons and other abscess cavities subside promptly when thoroughly cauterized with carbolic acid, after evacuating the pus.

In using carbolic acid it is important to know that tendons and aponeuroses may be quickly destroyed by the stronger solutions. This dressing should never be used where important tendinous tissue is exposed, as may occur in the forearms, hands and feet. Carbolic dressings are rarely poisonous. I have seen one case where a large abdominal wound was irrigated daily with a carbolic solution, and dressing of the same applied. The patient began to complain of numbness of the skin, especially up and down the right side, and the mouth and tongue felt as if cocaine-ized. The appetite became impaired and the urine dark. Changing the irrigation to plain water, and applying balsam of Peru and castor oil dressing, the symptoms subsided in a day or two.

Formalin.—The introduction of formalin, a solution of formaldehyde gas in water, seemed at first to meet all demands in a surgical dressing, it being a powerful germicide and non-toxic; but practice has proven it otherwise. It is a good dressing for closed wounds, and may be applied every two hours, like bichloride, to subdue inflammation. It is an excellent substitute when frequent bichloride dressings cause a dermatitis, but it is not so desirable on open wounds.

A solution of 1 drachm to the quart is the usual strength, but even this will cause the patient the most intense suffering.

When a healthy granulating surface is treated it soon be-

comes covered with a dry, black slough. The wound continues to heal under this aseptic slough, but the healing process is retarded, and the skin makes very slow advance over the wound until the slough is cast off.

The skin surface must be watched lest the hardening or tanning action of the formalin destroys the skin itself. When the skin begins to assume a brownish appearance the formalin dressing must be discontinued. Aside from these disadvantages it is a good antiseptic dressing.

Picric Acid.—So valuable a dressing as picric acid solution in the treatment of burns cannot be too highly recommended. One of the most distressing injuries a physician or surgeon has to deal with is a good-sized burn. The destruction of a large area of tissue means months of patient attendance and much pain to the injured. For this injury there is no dressing that is so effective and prompt in its action as picric acid. It is especially valuable in burns of the first and second degree, but even burns of the deeper tissues heal kindly under the treatment.

Bicarbonate of soda solution may be used at the first dressing to allay pain and because it is quickly obtained, but after the first twenty-four hours no other dressing than picric acid should be used. At each dressing the blebs should be punctured at the base and the serum pressed out; and in a day or two this skin will seem to graft itself on the surface beneath. The sloughs formed by deeper burns are hardened and are cast off gradually. I have seen extensive burns about the face and hands which, from the large blebs formed seemed to involve the deeper tissue, almost entirely healed in the course of a week.

Picric acid is also a valuable dressing for indolent ulcers, of which the varicose ulcer is a characteristic example. In a few days they undergo a marked improvement. The granulations become red and healthy and the skin edges begin to grow. The solution is used in its full strength, $37\frac{1}{2}$ gr. to the pint, with $\frac{1}{2}$ ounce alcohol added. Recently, the use of the saturated solution without alcohol has been suggested, it being less easily absorbed by the system, and therefore less toxic.

Creoline.—Creoline is used in the strength of 1 drachm to the quart of water. It is valuable for irrigation where strong antiseptics are contra-indicated, such as in the pleural cavity

after an incision for pyo-thorax, and in intra-uterine irrigation. It is excellent, too, in foul-smelling wounds.

Boric Acid Solution.—This is a mild antiseptic, and has no special virtue other than being non-toxic and non-irritating, and may be used advantageously on mucous surfaces and injuries about the eyes. As a dry dressing I will speak of it later.

Peroxide of Hydrogen.—The use of peroxide of hydrogen in suppurating wounds is not as popular as it was once. It may be used to advantage in very unhealthy abscess cavities, to get rid of sloughing tissue, for one or two dressings, but its continued use causes the granulation to become pale and flabby, and it does not prevent the re-formation of pus. Its principal use, then, is the cleansing of abscess cavities when first opened.

Citrate of silver is a good antiseptic, but it has no special advantage.

Bromine and iodine are very old but useful drugs in offensive wounds. They are used in light lemon-colored solutions.

Dry Dressings.—Dry dressings or drying powders are used advantageously on small wounds which have begun to unite satisfactorily, and on granulating wounds over which the skin edges are already creeping. There is a large list of powder dressings on the market, but only a few have any special advantages.

Aristol is an expensive powder, but one of the very best. It is a mild antiseptic and a valuable cicatrizant. It is excellent in the last stages of wound healing, especially in granulating wounds where skin grafts have formed a few little islands and the skin is creeping out in all directions; it is an excellent dressing for all small wounds, and when covered with a bit of cotton and collodion no other dressing is required. It is a good dressing for burns when mixed with oil.

Iodoform one part to Boric Acid four parts is a stimulating dressing on granulating wounds, but its odor makes it very objectionable to some. Pure boric acid has a sphere of its own; it is in the treatment of deep discharging sinuses. A deep sinus which yields to no form of treatment will sometimes close up quickly when packed from the very bottom with powdered boric acid and no drain used. This dressing should not be repeated oftener than once in two or three days.

The Subiodide of Bismuth is another excellent drying powder,

and may be substituted for aristol. If the skin becomes too dry, and has a tendency to crack, an oily dressing may be used for a day or two. *The use of papoid or pepsin* powder mixed with boric acid is very effective where a large sloughing or gangrenous surface is present. These substances digest the dead tissue, and do not act on the living, so that the wound clears up rapidly; where a plain antiseptic dressing would take weeks to bring about a healthy condition.

Oily Dressing.—Of the oily dressings commonly used, I believe the most valuable is a 5 per cent. mixture of balsam of Peru in castor oil. It is antiseptic and very stimulating to granulating surfaces.

The same class of wounds for which carbolic acid solution has been recommended do well under balsam of Peru and castor oil. The unhealthy grayish surfaces soon clear up and become red and healthy. On ordinary granulating surfaces the gauze can be removed with much less pain when this form of dressing is used. Deep sinuses drain more freely when the gauze drain is saturated with the oil, and its introduction is much less painful. *Vaseline* is of little use as a surgical dressing. It is seldom aseptic, and is sometimes very irritating to the skin. *Aristol with vaseline* has been recommended for burns, but I have had no experience with it.

Nutritious Dressings.—There is a form of dressing now being somewhat used which is not an antiseptic, and yet may have a place in certain stages of wound healing. It is claimed by some that a dressing which contains some form of predigested nourishment, such as bovine or protonuclein powder, may be applied to a granulating surface, and the cells stimulated by direct feeding. No doubt the cells do absorb a certain amount of nourishment, and large granulating surfaces may do well under this form of treatment, but the surface should be cleaned at each dressing with an antiseptic wash, and this removed with sterile water. A malignant growth which I had been treating for some time in this way suddenly took on a most virulent form of infection. Evidently the powder itself had in some way become infected, and when applied to the wound had only served as a pabulum for the germs to feed upon. I should advise the use of this form of dressing cautiously.

SELECTIONS FROM RADEMACHER.

Translated and Condensed by

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NOTE.—The following section illustrates the method by which the Rademacherians selected their remedies. It enables us to understand their disregard of the prevailing diagnostic nomenclature and their classification of diseases as tobacco-affections, zinc-affections, iron-affections, etc., according as the disease was “under the healing power” of tobacco or other remedy.

BRAIN MEDICINES.

Tobacco.

In the year 1819 appeared the brain fever in which I learned the healing action of tobacco. Until this time there had prevailed a gastric fever in which alkalies and nux vomica were the remedies. Both disorders commenced in the same manner, with severe headache, lightly coated tongue and active fever, with full, quick pulse. To tell the truth, I was aware that the prevailing gastric fever had changed its character only by the failure of the remedies which, until this time, had cured quickly.

Experienced physicians will agree with me in the statement that it is difficult and often impossible to recognize the nature of a disease from the symptoms alone. It so happened that my first case of the new fever resembled the gastric fever in presenting biliary symptoms. It was the persistence of the severe pains in the head after the relief of the bilious symptoms which made me suspect that I had to do with a different disease. But what kind of a disease was it? Was it a primary brain disease or was it a disorder of the general organism, involving the brain secondarily? I knew that it was impossible to determine this point from the symptoms, and that I must act as does the chemist with his reagents, and bring my tried remedies in contact with the organism of the sufferer one after the other. Being satisfied from the failure of the formerly successful remedies that the disease was not an affection of the

biliary passages, I used first sodium nitrate, on account of the fever. I saw that it acted well, that is, the fever declined, but the severe pains in the head continued, and after three days I was convinced that the disorder was not under the healing power of sodium nitrate. I now used the two other ancient "universal remedies," iron and copper, one after the other. When given after the disease had lasted some days and the patient was very weak, he was invigorated by them; but the headache remained, the whole disease remained, and the beneficial action of the remedies was only temporary.

From the failure of the constitutional remedies I was convinced that the disease was a primary brain disorder, and came to the difficult question: What substance in all the broad, rich store of nature stood in a healing relation with this particular primary brain disorder?

Anagallis and hypericum, recommended as cephalics by the old Galenists, were useless. Camphor, recommended as a cephalic, influenced the brain unfavorably. Zinc relieved the delirium when present, but had no effect upon the headache and fever. At this time there came into my hands an old Dutch translation of Dodonius, and it so happened that my eye fell upon the description of tobacco. While reading this article, I remembered that at one time this plant was regarded as a wonderful remedy for all diseases. Having read the article, I wondered how it was possible that one medicine could cure such different forms of disease, and came to the conclusion that either the greater part of the cures related were falsehoods, or that tobacco must act upon the brain and spinal cord. The latter conclusion being most probable, I saw in tobacco a possible remedy for the brain fever that had heretofore resisted my efforts. Making a tincture from the fresh leaves of *nicotiana rustica*, and finding that doses of thirty and forty drops had no unfavorable effect upon me, I tried the remedy first in cases of non-febrile headaches, and relieved them quickly. I observed that when one-half ounce was taken in twenty-four hours the bowels became loose, and, having noticed that a diarrhoea occurring in the course of this brain fever rather aggravated than relieved, I feared that tobacco might affect the patient unfavorably. Having distilled the tincture, I found that

the tobacco spirit thus obtained cured the headache, and had no bad effect upon the bowels.*

While the tobacco spirit relieved the headache, it did not have much effect upon the fever, the fever being under the healing power of sodium nitrate; and I found that the best medicine was a mixture of two drachms of sodium nitrate, one-half ounce of tobacco spirit and eight ounces of water, giving a spoonful every hour. With this remedy I cured most cases in ten days; whereas, when left to itself, the disease lasted many weeks.

In some cases, when called after the fifteenth day, this mixture did not give its usual prompt relief. I then replaced the sodium nitrate with two drachms of red peroxide of iron, and ten grains of gum tragacanth to hold the iron in suspension, and found the same prompt relief as before. In other cases, when called late in the disease and delirium had developed, zinc cured not only the delirium, but the whole disease.

The symptoms of this disease were variable. One understands readily that when the brain is diseased the sympathetic or reflected symptoms may appear in all parts of the body. The chief symptom which distinguished this from other brain fevers was a severe drawing pain in the back of the head, especially marked in the region of the cerebellum. Some patients had an additional pain in the spine, between the shoulder-blades, and these had sympathetic chest disorders—even bloody expectoration.

In the case of a brandy-drunkard who died of the fever, I made an autopsy, but could find nothing abnormal in the brain or elsewhere in the body, except an unusual softness of the brain. As the autopsy was made twenty-four hours after death and the weather was cool, I regarded this softness as the result of the disease rather than of post-mortem changes.

Stramonium Seeds.

In the year 1821 I observed that the character of brain fevers had changed because the tobacco spirit no longer cured.

* Later, Rademacher used a *water*, Aqua Nicotiana, probably on account of the expense of alcohol. He states that it possesses the full curative power of the spirit. Take eight pounds of *freshly plucked* leaves of *nicotiana tabacum* (or *nicotiana rustica*), cut in small pieces. Add one and one-half pounds alcohol and sufficient water to distill off eight pounds. The preparation of the leaves must be begun immediately after plucking, as they soon undergo fermentation, causing an unpleasant tobacco odor in the distillate.

I was now as much at sea as before, and set about to discover the remedy appropriate to the new form of disease. The most pronounced symptom was still intense headache, and most cases presented high fever. But the pain had changed its location from the occiput to the forehead and vertex. There were now distinct intermissions in the headache; also pains in the heels and calves. Diarrhœa was more frequent than formerly, and the nose-bleeds, when present, were dangerous. The natural course of the disease was very long, three months or more, and involved great prostration and danger to life. In some cases delirium and sleepiness were present, and in these cases zinc was of service in restoring a clear mind, but the pains in the head and the fever remained unrelieved.

In selecting a remedy it was necessary to determine whether the condition was a pure primary brain disease, with sympathetic fever, or a mixed disease—that is, a union of primary brain disease and a constitutional fever; or a primary constitutional fever that had localized in the brain. Of these three possibilities, one must be true.

I soon saw that the sodium nitrate, formerly so useful, had no effect upon this fever. I changed to the peroxide of iron, which is the mildest of all iron preparations, and saw good results. At this time a case presenting profuse nose-bleed determined me to use a stronger iron preparation, and I gave a mixture of one ounce tincture of the acetate of iron, one ounce gum arabic and seven ounces of water, a spoonful every hour, the entire quantity to be taken in twenty-four hours. I soon saw that I was on the right track, for the vascular excitement subsided and the diarrhœa, when present, ceased. The headache, however, remained unrelieved; and by this I saw that it was a mixed disease; that is, a constitutional disorder, subject to the healing power of iron, combined with a primary brain disease, the remedy for which remained to be discovered. I had already used the acetate of zinc for the diarrhœa, with no relief of any symptom. I tried the cephalics of the ancients, hypericum and anagallis, without success. I now remembered that, a long time ago, I had cured a case of severe daily headache with stramonium, and to my satisfaction found that it relieved the head pains of the present epidemic.* The dose

* The Tr. Stramonium of the American homœopathic pharmacies is made from the seeds, as also that of the U. S. P., B. P. and Ph. G. The *British Homœo-*

adopted was one drachm of tincture of stramonium seeds every twenty-four hours. The stramonium had no effect upon the fever, but the addition of one drachm of stramonium tincture to the iron mixture already described gave me the true remedy for the epidemic. The fever diminished, the headache disappeared, and this lingering disease was cured in from eight to fourteen days.

Some cases with persistent diarrhœa required the addition of one-half ounce of tobacco spirit to the mixture, the reason for which I cannot explain.

In the non-febrile attacks I observed that the pain was located in the right side of the head. It was intense, with little remission. In one such case I increased the dose of stramonium to one and one-half drachms during the twenty-four hours, curing the patient.

Chloride of Silver.

(In attempting to prepare a silver tincture described by Woitz, Rademacher noticed that the moist chloride of silver lying on the filter paper had a bluish tint, and the thought occurred to him that this might be the mysterious *argentum lasureum* praised by Paracelsus as a cephalic.)

I have not used this remedy as frequently as the other cephalics because the head disorders which are under its healing power have not often presented themselves. The most important experience that I had with it was in 1824. Until this time the brain fever, which was under the healing power of stramonium and iron, had prevailed. In September of this year the disease changed, so that it was no longer curable by these medicines; but I found the remedy in chloride of silver. There was no great difference in the symptoms of these two fevers, except that in the chloride of silver affection the pains in the head were not so intense, or even absent, and all the patients complained of a peculiar vertigo or giddiness, such as is often noticed as a forerunner or accompanying symptom of nervous fever or bilious fever. The most certain sign of the change in character of the disease was the failure of the accustomed remedy to cure. This disease required two weeks to cure; but as the natural course of the disease was prolonged

pathic Pharmacopœia directs it to be made from the whole plant when bearing both flower and fruit. It is probable that there is little or no difference between the effects of the two preparations.

and accompanied by great prostration, a cure in two weeks' time was of great advantage.

Artemisia.

A boy suffering from epileptiform attacks following measles was relieved of a mass of round worms, but the convulsions persisted. In this case silver was given as a brain remedy without success, but powdered artemisia root cured. It is probable that artemisia will prove a remedy in some primary brain disorders. I do not know what nosological name to give such a disease, but I believe that just as I have seen brain fevers that were under the healing power of tobacco, stramonium and silver, so may I also see brain diseases that are under the healing power of artemisia, anagallis or hypericum. Remedies to which we can ascribe a direct healing power toward a diseased organ are of great value to the practical physician. Not that we can use them daily, but that, sooner or later, diseases appear in which the one or the other is the true remedy, and helps us out of our difficulties. It is folly to reject a remedy because in a certain limited time we have not had the opportunity to test its healing power.

CUPRUM.

BY C. S. SCHWENK, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, September 29, 1899.)

CUPRUM is a remedy with which we are all very well acquainted; therefore, its selection as a subject for a paper had in it the object of illustrating how briefly a remedy might be described for all general working purposes. Cuprum has symptoms of a violent nature; their intensity suggesting an irritant of tissues, a poison. Its irritating, inflammatory and constricting influence is manifest throughout the drug. Blue face and lips; blueness of the skin; intense coldness of the surface; cramps of muscles; muscles of thighs and calves drawn up in knots; flexors are markedly involved; thumbs drawn across the palms. Distress in the epigastrium, associated with the most intense dyspnœa; great anxiety; frothing at the mouth;

thirst, or rather a desire for water because it relieves the vomiting or cough, if either of these symptoms happens to be present. Great sensitiveness to touch. Diseases caused by vexation, fright, or suppressed eruptions.

Is it necessary to have more than this? In the foregoing we have the genius of the remedy, and that is sure to be present in whatever condition, complaint, disease, functional or organic, in which cuprum is the remedy, and it is a very easy matter to prove this by quoting from different authors recommending cuprum in various disorders.

Farrington said: "Cuprum not only acts upon the bowels, inflaming them, but it acts upon the nerves, causing constriction of fibre, particularly of the involuntary muscular fibres, as in the blood-vessels, and with this we have direct irritation producing inflammation. Now, to clearly understand the character of cuprum, you must remember the other side to this picture. This condition is soon followed by collapse with great prostration, from which it is exceedingly difficult for the patient to rally. Thus we have as a remote symptom of cuprum, and one, too, which has been greatly neglected, lack of reaction."

Allen, in his clinical description of cuprum in fever, writes: "Intermittent fever, with icy coldness of the whole body; predominating cramps in limbs; blue surface; collapse; suppression of urine."

Scarlatina, by Lilienthal: "Convulsions before the eruption breaks out, or when the eruption suddenly disappears, with tendency of metastasis to brain; quick, small, irregular pulse; low temperature; sopor; rolling of eyes; facial distortion, and also of all flexor muscles; great restlessness; throwing the body about; spasmodic action of chest; vomiting; cold face, blue lips, coldness all over; aggravation by contact."

Malcolm and Moss in their regional and comparative *Materia Medica* speak of cuprum as follows: "Cramps in limbs. Weariness of limbs, contraction of joints. Limbs cyanotic."

Guernsey, in recommending cuprum as one of the remedies for diseases of the brain, writes: "Convulsions and cramps are marked features of the case requiring cuprum. The cerebral disease is the result of metastasis during an attack of catarrhal or exanthematic fever. The spasms and cramps commence in

the extremities, and especially in the fingers and toes. Inability to hold the head up. Grinding of the teeth."

In Bell and Laird the italicized symptoms only have been selected in their description of it: "Vomiting relieved by drinking cold water; restlessness, tossing about and constant uneasiness. Sunken, deep eyes, with blue rings around them. Desire for warm food and drinks. Violent vomiting of bile; of water containing flakes, with violent colic and cramps. Spasm of the stomach. Deathly feeling of constriction beneath the sternum. Violent spasms in the abdomen and upper and lower limbs, with piercing screams. Spasms of the throat, preventing speech. Dyspnœa so intense that he cannot bear a handkerchief before the face. Violent cramps in legs and feet. Intense coldness and blueness of the surface, with long-continued general cold sweat and great prostration. General convulsions, with continued vomiting and violent colic. Uræmic eclampsia, with loquacious delirium, followed by apathy, cold tongue and breath and collapse. Spasms, with blue face and thumbs clenched across the palms of the hands. The cramps particularly affect the flexors, the muscles often drawing up into visible knots."

Now, there it is, the same thing over and over again. More of it can be found in Hering's *Materia Medica*, and still more of it in his *Guiding Symptoms*.

By actual count it requires less than one hundred words to describe cuprum in such a manner that it would be of practical working value, and about eight hundred words to back up the statement.

Cuprum has not less than seven hundred symptoms, and each symptom has its value.

It would be possible to commit to memory all of the symptoms of cuprum, but to memorize all the symptoms of all the remedies would require a brain run by a different motor than the one in use at present; therefore, we must devise a plan by which these valuable agents may be accurately utilized. No one could give an intelligent description of cuprum, or of any other remedy, without incorporating its genius, any more readily than they could prescribe the remedy and claim that it was indicated if they were not entirely influenced by that genius. The stuff might be descriptive of any remedy, and

about as recognizable as a butterfly without wings wandering about as a freak nondescript.

Vomiting, purging, pain, headache, prostration, vertigo and chilliness. That would describe lots of cases, but it would be absolutely bereft of any therapeutic value; and yet, such a case could not exist without being stamped by an individuality; more than that, the genius of a drug would be there to direct us in our selection of the appropriate medicine, and all of us have experienced what the accurately-applied remedy will accomplish. We have seen it arrest and cure cases, or, in event of a fatal illness, we have seen the comforting effect of amelioration.

However, whether the patient improved, got well or died, haphazard guesswork in therapeutics passed into antiquity when the law of similars exalted medicine to the position of an exact science.

PUERPERAL SEPTICÆMIA.

BY D. C. KLINE, M.D., READING, PA.

(Read before the Homœopathic Practitioners' Association of Reading, Pa., July 25, 1899.)

OF all "the ills that mortal flesh is heir to," and particularly flesh of the lying-in room, perhaps none is more distressing or heartrending to behold than puerperal septicæmia.

The poor woman has just passed through a nine months' travail, constantly looking forward to the happy hour when she will be relieved of her burdensome weight, and be able to behold the God-given treasure with that happy good cheer which none but a true mother can appreciate.

She has enjoyed a few hours' respite, when behold her disappointment if she is suddenly aroused with those three characteristic symptoms of puerperal septicæmia, viz., chill, pain and fever.

These three symptoms are certain to be present, although in greatly varying degrees—from slight chilliness, an uneasiness in abdomen and uterine region, with a rise perhaps of half a degree of temperature to a most decided shaking chill; severe distressing pains, with a sudden jump upward of several de-

grees in temperature. The septic condition may appear very soon after labor or not for several days; most frequently, however, in about thirty-six hours; and yet the time must necessarily vary according to the time of infection, whether this takes place at the time of labor or hours or days after.

It is now pretty generally acknowledged that in true puerperal septiciæmia the infection is conveyed to the patient from without, causing blood poisoning, wound infection. The infection may occur by the poison or pathogenic microbe being conveyed direct to the abraded perinæum, cervix, or through the uterus, or the remnants of retained placenta may become infected, and thus set up decomposition. Thus the absorption of this poison causes a septic condition of the uterus, or the secundines coming into the vagina or vulva. Coming in contact with the atmosphere, putrefaction takes place, and certain ptomaines are readily produced and the system poisoned.

Grandin and Jarman state that "in putrefactive tissues micro-organisms are at the bottom of the process. Infectious material is thus produced; and if the excretions of these substances are interfered with, septic infection results. Now the very entrance of these micro-organisms interferes with excretion, and therefore we possess in the body, under the given conditions of putrefaction, material which not alone may poison, but which may interfere with excretion, from which, necessarily, infection will result."

Bacteriologists have demonstrated by experimenting that there are hosts of bacterium varying somewhat one from another, any one of which may be the source of septiciæmia or pyæmia.

The line of symptoms produced will necessarily vary in each individual case, in accordance with the kind or kinds of micro-organisms which have gained entrance into the system, and according to the nature of the soil where they have lodged. In many patients we find a special idiosyncrasy; their system is in such a condition that poison is the more readily absorbed, and nature, with them, cannot combat and throw it off so readily as in another. In the other instance, the condition of the patient may be such that the micro-organisms, though present, may be thrown off, and but little or no ill effects produced.

All septic conditions are undoubtedly aided in development by unhygienic and filthy surroundings, although not directly produced by it.

Now, if puerperal septicæmia is caused by the pathogenic microbe being conveyed to the patient from without, then what is the source of infection? Patients themselves, no doubt, frequently convey the germs by the attempt to care for themselves while their hands are decidedly unclean; they not infrequently attempt an examination of the perinæum and labia after labor; wash themselves with a cloth from perhaps a thoroughly unclean basin, water and soap that have collected all the dust and dirt in the room; or the old housekeeper, serving as nurse, who has no conception of asepsis, as the dear old soul I once asked to wash and disinfect her hands before washing the lying-in patient angrily replied that her hands were always clean. (My reply was: her hands might be clean enough to bake bread, and yet not sufficiently clean to wash our patient.)

The difficulty appears to be for doctors, nurses, patients and all to appreciate the vast difference between socially or æsthetically clean and surgically clean.

I have known physicians to enter the lying-in room and proceed to make a digital examination without washing or disinfecting the hands; practice such as this is next to criminal.

The use of a syringe with an old or filthy nozzle is often the source of infection. By far the safer plan here is the use of a glass nozzle, which can readily be boiled and made sterile.

The physician should remember that he is the one in charge of the case, and he should give positive instructions as to the manner, method and care of the patient, repair promptly all perineal rents or lacerations, and, if necessary, dress them daily, or oftener, himself. If the vaginal douche is desirable, let us be ready to give it ourselves rather than trust an incompetent person, for, mark you, in private practice we cannot always have a trained or competent nurse to carry out our orders.

When a patient has suffered from an endometritis, and endured an ugly leucorrhœal discharge, whether it be specific in origin or not, or where we are inclined to believe portions of

placenta or secundines are retained, the immediate use of the intra-uterine douche or dull curette after labor is quite desirable, thereby preventing the likelihood of septic infection from this source. If done aseptically, there is absolutely no risk, and the results are gratifying.

In private practice this is not always convenient, and yet can be accomplished when entirely alone with the patient. If my confinements were all in hospital service I should use the intra-uterine douche in a large percentage of cases.

Let us remember that to allow a woman to develop puerperal septicaemia is a serious matter; distressing as the immediate results may be, the evils do not end here. A woman who suffers a severe septic condition and survives is very liable to become a chronic invalid or lifelong sufferer—one degree of pelvic inflammation may follow another until her life becomes burdensome. Some of the most serious cases in the ultimate results are those in which the septic manifestations are comparatively mild; hence they receive less careful and less persistent attention and treatment.

In a large proportion of cases puerperal septicaemia develops from the uterus. If the treatment be prompt and efficacious, the spread of the disease may be held in check; if not, the poison may continue to spread until other organs become involved or the entire system is poisoned.

The lymphatics of the uterus may absorb the virus directly, or there may be a decomposing mass which becomes infected, and through this means we have first a sapraemia, *i.e.*, poisoning of the system from absorption of the products of decomposition, and then septicaemia develops with the endometrium as the first local lesion.

Where there is a marked systemic involvement, one important diagnostic point is the decided rise of the pulse-rate in proportion to the temperature—the pulse may be 140 or 150 per minute, while the temperature may not exceed 100 degrees. Where, however, the lesion is more of an acute inflammatory type and the general systemic involvement is slight, we are apt to have a high temperature and a slow pulse-rate.

With the rise of pulse and temperature the lochia may become diminished or cease altogether, and there may be decided fetor, although these symptoms of the lochia are oftentimes mis-

leading, as in a case seen recently in consultation, where there was a considerable lochial discharge and scarcely any fœtor but a high pulse-rate and temperature, all of which was naturally misleading to the physician; but the intra-uterine douche, twice daily, promptly lowered temperature and pulse and changed the character of lochia.

The decomposing placenta or clot is most frequently the source of marked fœtor, and hence would indicate the immediate use of the intra-uterine douche or curette, and yet I am well aware that some able physicians are decidedly averse to the frequent use of the douche or curette. Nevertheless it may be used without any hesitation, if done carefully. In the most severe type of sepsis we may have scarcely any fœtor.

The digestive organs are readily influenced by the puerperal sepsis, particularly where there is systemic involvement, and constipation may become a very annoying feature; paresis of the intestines may supervene, and hence tympanites, pain in the abdomen, disturbance of respiration, owing to pressure against the diaphragm, nausea and vomiting, sallow complexion, sweetish odor of breath, etc., may appear, until the condition assumes a typhoid appearance.

In fact, each organ and portion of the body may become affected by the septic processes, and ever thereafter carry the evil influences.

One point of especial importance and worthy of consideration is that the physician or nurse who is so unfortunate as to have a full-fledged puerperal septicæmia case develop under their care, should not attend an obstetrical case for some time after, for it is a well-recognized fact that the pathogenic microbe is frequently conveyed from one patient to another in this manner, and an individual physician may in this way have an epidemic of cases and be the means of numerous deaths.

Suppose a patient has passed through labor apparently safe, and we believe she has been delivered aseptically, but, notwithstanding this, we are hurriedly summoned to her bedside, and find her with rigors, rise of temperature and pulse, the lochia has suddenly ceased or changed in character, some fœtor, tympanites of the abdomen, etc., thus picturing to us a septicæmia. What shall be our line of action to, if possible, afford relief and restore the patient to a normal condition? Our first

thought will be the selection of a remedy. Let it be acon., ars., or ars. and china combined. Bella., baptis., kreoso., lach., verat., or any one of a large number may be selected, according to the symptomatology.

If the case progresses to a severe systemic form, stimulants may be required, forced feeding will become necessary, the food should be given in concentrated form.

If the lochia has diminished a *vaginal* douche of hot water, from 110 to 115 degrees, may assist. If there is any possibility of portions of placenta or secundines being retained, then, as previously stated, the uterine curette may be called into service, accompanied by a uterine douche of bichloride 1 to 4000. The curette should be used carefully and thoroughly, but should not be repeated. If one thorough curettage of the uterus does not suffice, a second or third will not only do no good, but is very liable to do harm. However, the uterine douche may be continued indefinitely or repeated frequently. If the douching is continued or frequently repeated, then it is far preferable to continue with only sterile water, and not any strong disinfectant.

The continued irrigation seems quite a rational treatment. Dr. Mauseau, of Montreal, cites a severe case of septic metritis in which he continued the intra-uterine irrigation for a period of forty hours, with four intermissions of 1 hour each, the flow being at the rate of from 7 to 12 gallons per hour. The temperature promptly came down from $106\frac{1}{2}$ degrees, but during each hour of intermission the temperature would rise from $\frac{1}{2}$ to 1 degree. This irrigation was continued at intervals for ten days when convalescence became permanent.

Saline (salt) injections in the bowels, abdomen, or underneath the breasts, or the saline solution injected directly into the circulation by venesection, is a rational method of treatment; it stimulates and increases the force and volume of the circulation, and will certainly aid in eliminating the poison from the system.

Dr. Noble, of Atlanta, advocates the intra-uterine use of alcohol. This may have a twofold action—first as a stimulant, and secondly as a disinfectant. After cleansing the uterine cavity, introduce a sterile rubber catheter, with a strip of gauze attached, and insert the gauze around the catheter, packing

lightly. A few drachms of alcohol is then injected through the catheter every 15 to 30 minutes until improvement takes place, and as the case progresses the intervals are increased. The dressings may be left in place for several days.

The antistreptococcic serum has its advocates, and no doubt does efficient service in selected cases—more particularly in the systemic variety. Dr. Williams, also Dr. O'Connor, reports cases in *The Philadelphia Medical Journal*, where seemingly very excellent results have been gained by the injection on alternate days of antistreptococcic serum; they, however, used other methods of treatment. Dr. O'Connor particularly speaks of intra-uterine douches of bichloride 1 to 4000 being used twice daily.

Puerperal septicæmia is a treacherous disease, and one oft-times difficult to combat; we should be broad in our views, and ready to make use of any means of treatment offering us any probable assistance.

I question whether there is any one line of treatment offering as good results as the frequent and copious intra-uterine douche, be it combined with a disinfectant solution or simply the sterile water, at a temperature varying from 110 to 120 degrees, according to the susceptibility of the individual patient. These injections are applicable whether the endometrium be the origin of the disease or if it be purely systemic.

The injection of saline solutions into the circulation through venesection, or by way of the bowels, abdomen or breasts, will no doubt prove useful in the future.

GASTROSTOMY FOR BENIGN STRICTURE OF THE ŒSOPHAGUS.

BY H. L. NORTHROP, M.D., PHILADELPHIA.

ALTHOUGH this little patient says "ice cream tastes better by the mouth" than it does through her gastric fistula, she is nevertheless thankful that she has an artificial channel leading into her stomach, for she is intelligent enough to appreciate the fact that it was the means of saving her life, and that she must now depend upon it for further nourishment.

She was sent to Hahnemann Hospital by Dr. T. L. Chase, on

July 14, 1899, and we were told that she was 8 years of age, and had enjoyed good health until December 17, 1898, when she developed scarlet fever and was sick for sixteen weeks. Convalescence was about complete when, late in March, a lump appeared in the left side of the neck below the ear. This increased in size and "looked like a blind boil:" did not come



to a head, and poulticing had no effect upon it. The physician in attendance at the time lanced it, but found no pus. Difficulty in swallowing occurred simultaneously with the supposed abscess, and when the latter disappeared total œsophageal obstruction followed.

On July 15th I attempted the passage of bougies, but found it impossible to even enter the œsophagus, the instruments

stopping at the level of the cricoid cartilage; the smallest size used was 14 F.

My finger introduced into the pharynx would not enter the œsophagus, which felt hard, like cicatricial tissue, and seemed to be completely occluded.

One ounce of water taken into the pharynx would be regurgitated in a few minutes, exactly the same quantity as introduced. Nutritive enemata had been used for weeks, and the sphincters now refused to retain them.

The child at this time was weak and emaciated, and sank into a pronounced typhoid state. In order to avert death by starvation, which threatened her, I performed gastrostomy on July 20th, as described by Marwedel in the *Beiträge zur klinischen Chirurgie*, 1896.

After opening the peritoneal cavity by Fenger's oblique incision, which runs parallel to the costal border on the left side, the anterior wall of the stomach was stitched with fine silk to the parietal peritonæum near the edges of the wound. This shut off the peritoneal cavity. The anterior wall of the stomach was next incised obliquely downward and to the left for a distance of about two inches, the incision being carried through the serous and muscular layers only, which were dissected loose from the submucosa on each side, to make a bed for the rubber tube now to be placed in the gastric wound. This tube (a soft rubber catheter, No. 20 F.) was then incorporated in the stomach wall by sewing the sero-muscular flaps over it with fine black silk. At the lower angle of the stomach-wound a small opening was made through the mucous membrane, and the rounded tip of the catheter was introduced into the cavity of the stomach. A final stitch closed the stomach-opening tightly around the catheter. The closure of the abdominal wound followed, and before applying the bichloride dressing two ounces of warm peptonized milk were injected into the stomach through the catheter. Time of operation, one hour and ten minutes.

No post-operative complications occurred. Because of the pronounced state of inanition, inunctions of cod-liver oil and coca butter were given alternately every four hours; nutritive enemata were given every four hours; the stomach received two ounces of peptonized milk every two hours, with one grain

of arsenic, 2x, dissolved in the milk. Later, a special liquid diet was given.

And now comes an interesting point in the case. While her dysphagia varied in degree last spring, it was literally complete for several weeks before the gastrostomy. As far as could be judged, not a drop of fluid passed beyond the point of obstruction. One ounce swallowed (?) was ejected, one ounce by meas-



urement. However, one week after the operation it was found that swallowing was possible, and to-day four ounces of liquid can be disposed of in from forty-five to sixty minutes. This gives us hope of yet being able to accomplish something by dilatation.

The tube is not worn continuously, and there seems to be no tendency upon the part of the fistula to contract.

As to the kind of obstruction present in this case, I believed from the beginning that it was cicatricial, the result of a deep-seated abscess, which perhaps ruptured into the œsophagus, or disappeared by absorption. In either case a cicatrix could result. To be sure, cicatricial strictures of the œsophagus are commonly caused by the swallowing of lye, ammonia, acids, etc., and also by tubercular and syphilitic ulcers. They are usually situated at the beginning of the œsophagus,—the level of the cricoid cartilage. Richardson (*Boston Medical and Surgical Journal*, January, 1892) and Zenker (*Observata Anatomica*) each reports a case of cicatricial atresia of the œsophagus, though in neither case could a history of swallowing an escharotic be obtained, nor could any cause whatever of stricture be found.

After presenting this case to the Society I made several persistent attempts to introduce a bougie into this child's œsophagus, but failed absolutely. At times swallowing is improved, and sixteen ounces of liquid food will disappear in forty-five minutes. The patient's general condition has changed wonderfully for the better; still, I intend to make further efforts to dilate the œsophageal lumen at the point of obstruction.

NOTE ON THE DETECTION OF ALBUMIN IN THE URINE.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

THE writer notices with some satisfaction that the cold nitric acid test is not thought sufficient by modern writers to detect traces of albumin. For example, in an article in the *HAHNEMANNIAN* for December Dr. Pritchard says: "It will not suffice for detecting mere traces." Inasmuch as this test is used by many life insurance examiners, we can see how it is that patients with slight chronic albuminuria so often get their policies.

I have discussed this matter in an article published in the *New York Medical Times* for November, 1899. Dr. Pritchard further mentions the fact that Spiegler's test is complicated by phosphates, and that "this is not mentioned by Spiegler nor any other writer." In this I must modestly differ with him, as I called attention to the ring with phosphatic urines caused by

Spiegler's test in an article on cystic kidney published some months ago in the *Philadelphia Medical Journal*, and supplemented it by an article in the *New York Medical Times* for November, giving, among other things, the results of an inquiry into the precipitate produced in phosphatic urines, and nearly all urines, by Spiegler's test. As I showed in the last-named article, the precipitate is not due to phosphates at all, or at least not wholly, since prior addition of a strong solution of calcium chloride to the urine and filtration does away with the substance, which in all probability is an alkaline carbonate, or a mixture of alkaline carbonates with phosphates. The writer hopes that the matter of tests for albumin will receive further attention in the journals, as it is, in his experience, a difficult thing to obtain a delicate test which is at the same time reliable.

THE OPIUM HABIT.

BY AMOS J. GIVENS, M.D., STAMFORD HALL, STAMFORD, CONN.

OPIUM and its history dates from the third century before Christ. Its chemical composition and medicinal uses are well known; consequently, I shall not enter into detail concerning them, but will describe the dangerous and dreadful habit instead.

Opium addiction is a disease of modern times, found in all classes of society, and the great increase is enough to startle any one. In 1767 the East India Co. first shipped gum opium to China, where the consumption soon became enormous. Its use became so great and caused so much misery and poverty that the government tried to check it by legislation. In 1840 the Emperor ordered all the opium destroyed, but in 1860 it was again readmitted and its sale legalized.

Forty years ago the opium habit commenced developing in the United States, and in 1843 the hypodermic method of using it was discovered. In eastern countries the favorite method is smoking, but in the United States it is usually taken by the mouth or syringe. In 1870, 158,000 pounds of opium was imported into this country; in 1880, 343,000 pounds; and in 1890, 500,000 pounds, or 250 tons, one-half of which, it is esti-

mated, was used in medicine. It is computed that 100,000 people in the United States are addicted to its use.

In referring to opium addiction we include all its preparations, as their effects are practically the same when taken for a length of time. The sulphate of morphia, however, is most frequently used.

Of 235 cases analyzed by a Chicago physician, morphine was used in 120, tincture of opium in 30, McMunn's Elixir in 2, paregoric in 5, gum opium in 50, Dover's Powder in 1, unknown, 27. Sixty-six were males and 169 females.

The tremendous business pressure and strife, and the bustle and worry of our modern times, are increasing this class of cases.

The opium habit and its consequences are well described in the writings of DeQuincy, Fitzhugh, Ludlow and Coleridge; in fact, DeQuincy's first book, *Confessions of an Opium Eater*, excited the interest and curiosity of the laity.

Among professional men, many doctors are victims. Of 50 cases cited by Earlenmeyer, 16 were doctors. Of 110 noted by Livinstein, 35 were doctors; and of 300 cases, 124 were doctors.

The effects of opium vary somewhat, according to the temperament, and are also influenced by the powers of imagination, methods of thought, etc. The poet experiences sensations unlike those of the dull, plodding laborer, and the effects upon the imaginative races of the East are different from those upon the dull Anglo-Saxons.

The Symptoms.—There is always a greater impairment of the appetite when opium is taken by the mouth than when taken hypodermically. Catarrhal inflammation of the stomach and small intestines is observed; there is partial occlusion of the bile ducts, and different degrees of jaundice results. The bowels become constipated, and often, in the advanced stages, constipation alternates with diarrhœa. The skin generally presents a pale, cadaveric appearance, due to the poor action of the liver; the functions of the sebaceous glands are lessened, and the skin becomes dry and brittle; there is often hyperæsthesia, with great sensitiveness to cold; the eyelids and face become puffy and swollen from dropsical effusion.

Upon the sexual organs the desire at first is increased in

both sexes; but this almost universally gives way to impotence and sterility as the habit progresses. The menses in women become irregular, and finally cease altogether.

The urea in the urine is lessened and uric acid increases; albumin and sometimes sugar are present, but disappear when the habit is broken. Morphine is found in the urine, and Livinsteen says if it is found six or eight days after its use is supposed to be stopped, the patient is using it clandestinely.

The circulation is often disturbed, there being headache, flushing of the face, flashes of heat, and, in some advanced cases, a form of intermittent fever with chills. If abscesses intervene, their appearance may be first indicated by fever and some constitutional disturbance.

Sometimes a hypodermic injection may enter a vein; this irritates the vasomotor system, and congestion of the head and lungs may be produced. There is often tremor on writing. The knee-jerk is influenced. If absent, we have to suspect *tabes dorsalis*; if increased, we think of neuritis and spastic paralysis.

The mind is generally affected, but not to the degree of insanity, for that seldom results directly from the habit. There is a weakness of the will and perversion of the morals, loss of memory, and morbid impulses of various kinds. There is also a disposition to be untruthful about the drug.

The size of the dose of the drug is sometimes remarkable. Ordinarily the medicinal dose of the drug is one-quarter of a grain, but DeQuincy, it is said, took 1000 drops of laudanum a day. Several patients have come under my observation who have taken a bottle of morphine, containing sixty grains, a day, and one woman took twelve ounces of laudanum daily.

Of late, the treatment of the opium habit has received the attention that it deserves. The vice theory should be eliminated; the case should be regarded as a distinct disease, a neurosis.

It must be borne in mind that there is no specific; each patient should be treated in a scientific manner, based on rational principles. The temperament and constitution of the individual must be considered, and care must be used in assisting the patient in completely regaining health.

There are substitutes, but substitution does not cure; in fact, there are many nostrums advertised, which contain nothing but disguised solutions of morphine.

Dr. Samuel Abbott, health officer of Massachusetts, in his official report for 1886, says: "Of twenty samples of so-called opium cures which have been obtained, all but one contained morphine."

In the treatment of opium cases the most important thing is for the patient to voluntarily place himself under the supervision and observation of a physician in a sanitarium where such patients are treated, but never under the care of a doctor who has taken the drug himself. It is useless to attempt to carry out any line of treatment in the patient's own home, or anywhere but where the physician can direct and control the patient; for very few persons have sufficient will-power to carry out any plan of treatment unaided. Co-operation on the part of the patient is desired. Patients of long standing have weakened will-power, and sometimes find it difficult to give earnest and intelligent support. There are three distinct methods of treatment:

- (1) Abrupt withdrawal—the Livinstein method.
- (2) Rapid reduction—the Earlenmeyer method.
- (3) Gradual reduction—the Leahr-Burkhardt method.

(1) With the Livinstein method the patient is at once deprived of morphine. This plan is unscientific and barbarous, and attended with too much danger. If you go to Germany to-day, you will see the famous hospital of Livinstein. The patient is admitted for treatment; perhaps voluntarily places himself under the conditions of relief. He is put in a padded room; the walls are carefully protected; every particle of furniture is taken out, and a strong, trained attendant is placed there with him; there he is kept, and there he must suffer.

The patient gets nervous and restless; he stretches and yawns; he has coryza and sneezing. The intestinal tract, which has been partly paralyzed, is forced into an excessive and sudden secretion, and a profuse diarrhœa results. The greatest danger is of collapse and paralysis of the heart. Livinstein says that collapse may occur without any warning, without vomiting or diarrhœa, and when we least expect it. There is great danger; the trifling with a human life ought not to be.

Tuke says: "There is a certain organic change in the cell-structure of the nervous system when the use of narcotics are continued for any length of time, and these centres cease to act healthily or satisfactorily without the drug. The patient has been months or years developing a condition of the nervous system that is purely pathological."

Not infrequently despondency, mental indecision, and even mania, are the results of too rapid reduction. It has been wisely said that "the tyrant opium is bad enough without the tyrant physician to minister to its enthralled subject."

(2) The rapid reduction plan. This consists in withdrawing the drug in eight days to two weeks, keeping the patient in bed, well attended by experienced nurses and chemically restrained by bromides. Patients are almost unconscious from the effects of the bromides, which stupefy and deaden sensation. The dangers of collapse are not as great as with the Livinstein method. I have not used these two methods, as they cause too much suffering on the part of the patient, and are followed by a train of nervous symptoms which, as a rule, are not desirable.

(3) The gradual reduction plan. This is the most scientific, humane and rational, and is the approved method in this country. It is the one utilized in my practice and adopted by every patient who tries to break the habit himself, and is the one DeQuincy resorted to with success. The daily doses are gradually and progressively lessened. It is best that the patient give up the syringe, and that the drug be administered by mouth as soon as it can be done, but the amount should not be known to the patient. The rapidity of reduction depends upon the effects witnessed upon the patient.

Whenever the doctor detects a too marked nervousness, neuralgia or gastro-intestinal disturbances attendant upon a too rapid reduction, he must stop the reduction and permit the patient to become accustomed to the lessened amount. As the quantity becomes less, the reduction should be more gradual.

It is often desirable that the patient should be tapered off on some other hypnotic, such as codeine or sulfonal or trional, thus avoiding shock to a delicate nervous system. Bromides are contraindicated in all anæmic persons.

Patients are nearly always debilitated, and a nourishing diet

builds up the nerve centres and restores the blood corpuscles, which are always impoverished. The nutrition of the brain and nerve cells should be attended to. Sustaining nourishment should be regularly administered, and hot milk is of special advantage. Eggs and broths are allowed freely when borne well. Hot baths, as hot as they can be borne, are good. Hot salt baths, with friction to the skin, are of great value. With strong patients the cold douche along the spine may be beneficial, but there is danger of too great shock in weak and delicate persons.

Stimulants should be avoided or very cautiously prescribed. Opium and alcohol are both stimulants, and it is impossible to substitute one for the other without aggravating the condition we seek to relieve.

For the nausea, champagne is beneficial. Galvanism, especially in the neuralgia of the last stage of treatment, may be of value. A spray of ether, or massage, or bathing with alcohol may alleviate the muscular aches and pains.

Among the medicines used are the old, well-known remedies—*avena sativa*, *cannabis indica*, *digitalis*, *arsenicum*, *nux vomica*, *hyoscyamus*, *humulus lup.*, *belladonna*, *gelsemium*, *passiflora incarnata*, *phosphorus* and *caffeine*.

STROPHANTHUS.

BY ROLAND T. WHITE, M.D., ALLEGHENY CITY, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Phila., Sept., 1899.)

THIS remarkable tropical plant, interesting in its almost classic history as an arrow poison, is worthy of a more exhaustive study and a wider clinical application than can be devoted to it in this brief paper. The genus *Strophanthus* contains some twenty species, and are mostly climbing shrubs, all but one tropical, growing in equatorial Africa, southern Asia, and some of the Pacific Islands. The *strophanthus* seeds of commerce are mostly from the *Strophanthus hispidus*. These yield a neutral glucoside (an amorphous deliquescent powder, freely soluble in water and in alcohol), called stro-

phanthin, and an alkaloid called inæine. Strophanthin, the active principal, is supposed to contain all the poisonous medicinal properties of the plant, but, owing to the difficulties in obtaining, has had limited use.

The pharmacological action of strophanthus, summed up briefly, finds its chief action primarily as a muscle poison, affecting all striped muscles, but more vigorously the heart than ordinary muscular tissue. Post-mortem rigidity follows fatal doses without the heart relaxing from exaggerated systole, leading to the hypothesis of certain direct stimuli to motor centres and ganglæ. Blood-pressure tracings show no appreciable rise, which has caused observers to conclude that its marked diuretic action depends not so much upon its effects on circulation as a direct influence upon the secreting structure of the kidneys.

The therapeutic knowledge of strophanthus rests almost entirely with the clinician, there having been no exhaustive provings recorded; consequently, the following symptomatic applications are entirely derived from the crucial field of experience, which simply accentuate its homœopathic similia, based upon its toxic history. Compared with digitalis, we find in the effects of strophanthus some points common to both remedies, viz., they both increase the force of systole, and the primary effect to diminish the rapidity of beat with irregularity and variation of the rhythm. Strophanthus, not affecting the blood-vessels, causes but slight change in blood pressure, whereas digitalis causes increased tension and pressure of the whole arterial system, to which factor its diuretic properties are due. The gastro-intestinal disturbances are much less marked in continued exhibition of strophanthus than in digitalis. The action of strophanthus is quicker and more ephemeral than with its rival, digitalis, seeming also to have no cumulative properties.

We find the greatest sphere of clinical usefulness for strophanthus in the acute and functional disturbances of the heart, although it will prove often of great service in organic diseases. As arnica represents the panacea for bruised, tired and exhausted muscular tissue, so strophanthus will soothe and quiet a congested heart which is laboring and embarrassed by unusual strain put upon it; palpitation; irregularity, with pale

face; anxiety and faintness in athletes and wheelmen, with dull, distressing pain in the precordial region. Violent exertion, such as mountain-climbing, running, etc., causing painful, throbbing dyspnœa, with cyanosis and anxiety. Precordial pain long after the acute symptoms have passed away, the systolic beat remaining accentuated. Certain embarrassment symptomatic of circulatory disturbances during climacteric period, with aching through hips and extensor muscles of thighs, are promptly relieved by strophanthus. We find it more commonly useful among those active, energetic types of nervo-sanguine temperament, who have more energy and ambition than muscle, and are constantly exhausting and overtaxing the physical powers. Exaggerated cardiac action in these cases, with the concomitant train of conditions, can usually be controlled by strophanthus more kindly than by any other cardiac remedy. Dyspnœa and œdema are markedly ameliorated in chronic cardiac degeneration. The œdema of acute and chronic nephritis, in the earlier stages, is frequently benefited through the diuretic action of the drug, but later it does not have the prompt and decided effect which marks the exhibition of digitalis in these cases.

A SELDOM-RECOGNIZED FACTOR FOR SOME OF OUR FAILURES WITH DRUGS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Sept., 1899.)

EVERY physician of even feeble observing powers cannot have failed to note the wonderful efficiency of some one or more of the drugs he dispenses. Every time he prescribes the drug he gets an answer that is pleasing and satisfactory. He has been able to do with the drug all he could reasonably expect to do, and not unfrequently far more than he dared to hope. This drug becomes a pet one, and he relies upon it with a confidence born of oft-repeated favorable experiences. He learns, as it were, to swear by that medicine, and cherishes every drop of it. He looks askance as the bottle becomes

emptier and emptier day by day. In his admiration of the particular drug he does not recognize the fact that, within the sphere of its action, he has a right to ask every drug in his armamentarium to be equally as efficacious as his favorite and stand-by. He does not recall the thousand and one times that indicated drugs have failed. This is an awfully significant fact; but, with all its significance, the fact only serves as a background to enhance the special value of his wonderfully effective drug, and the pregnant meaning of the numerous failures with drugs where we have every right to expect beneficent action is lost sight of. This mental attitude is not to be wondered at when we take into consideration that the number of failures so overwhelmingly outnumber the favorable results. From the very frequency of failure the impression of unusual efficacy is enhanced, and a sub-stratum of doubt regarding drug action is unconsciously formed by the repetition of the mental concept of frequent failure, and unconscious mental pessimism is the consequence, and our almost constant attitude of mind toward a drug we have administered, unless it be our true and oft-tried friend, is one of expectancy, and we are not much disappointed when a drug fails to act. We often, in our chagrin, blame our power of selection, blame the failure on the lack of properly adapted strength for the individual we are prescribing for, accuse the patient of being irresponsive by reason of an idiosyncrasy, in fact, blame everything under the sun but the drug itself. We buy our drugs of a reliable house, and we believe, therefore, that the drug is blameless, and everything else blameworthy. Is this the correct position to assume? Personally, I am sure that in the vast majority of instances, at least, this is not the correct view. Before you pass final judgment, think of some other experiences you have had with drugs. When your bottle of old stand-by ran out, you hastened to have it renewed at the same pharmacy where you purchased before. You find the same color to your drug, the same absence of sedimentation, as was shown by your whilom friend, and in fact, you believe you are using exactly the same drug; and so you are, so far as the name, the maker, the pharmacy, the appearance, goes, but that fine-looking drug turns out to be a rank counterfeit, and disappoints you so often that it very readily takes its place among the vast array of un-

reliables. You have had that experience so many times that it, too, becomes quite a matter of course, and after a gentle swear-word or two you go on plodding away with the experimental method as of yore. Recall now some other episodes. How a certain case appeared to you to call absolutely and unequivocally for a certain drug, and you have given it without result, and you have run the gamut of strengths up and down several times, and finally, you, in desperation, have dropped the goods of your favorite pharmacist, and have gone into the drug store on the corner and bought a good supply of a measly-looking fluid extract, and you have given it with your usual feeling that you are going to fail, and lo, instead of failure, you have had a really brilliant result, and one, too, that thoroughly justified you in your conviction that you had selected the right drug, and that all you wanted was a medicine that would act as you had a right to expect it should act; for drugs are not for show, they are for work, and if they do not work, they are far more than useless, they are dangerous. By employing these useless stuffs we are losing time, prolonging suffering, inflicting unnecessary expense and anxiety, jeopardizing our reputation, making ourselves doubtful of our ability, and in an hundred ways retard progress in medicine, as well as in other obvious ways fail to fulfill our just expectations.

I personally recall several instances bearing directly on this point. I saw a case in a near-by city with a fellow practitioner, and recommended the administration of a certain drug. It was given for several days without result, and I was appealed to again by telephone. Satisfied that the drug I had selected was capable of doing the work I intended it to do in that particular case, I suggested its continuance, and that the medicine be given in such doses as would bring the desired result, of course increasing the doses gradually. I did not know at the time that the drug (which I had recommended in five-drop doses of the tincture) used by the physician in charge of the case was a fluid extract from one of the best known and most reliable old-school drug-houses in America. The attending doctor followed the directions very literally, until, indeed, he was giving his patient teaspoonful doses of the fluid extract, and that, too, without a particle of result. The medicine, even in these enormous

doses, for they were enormous, almost lethal, for this particular drug, had no more effect than so much filtered Schuykill. At this stage, I was again appealed to, and I suggested that he try the tincture of the drug made by a certain homœopathic pharmacy, and that it be given in the originally-recommended dose of five-drops. This direction was also followed, and lo and behold! the five drops of the tincture did more therapeutic work in twenty-four hours than teaspoonful doses of the fluid extract had been able to do in a week. In point of fact such a comparison as I have made is an insult to the tincture, for the fluid extract had been actually of no service whatever. One would be inclined from this experience to foreswear all fluid extracts, and to feel stuck up about his own tinctures, made with such alleged immaculate care. But, before drawing such an *ex parte* conclusion, let me present another little experience. I had a case in which I was sure that a certain drug was indicated, and gave it. No result followed. I repeated, thinking to give nature a chance to know that some one was on the track of stirring her up to her duty. No response. Of late years I have grown tired of accusing myself of inability to select accurately an obviously indicated drug. That little salve I seldom offer to my therapeutic conscience as of yore. The blaming I used to give myself has not taken all the self-respect out of me, and has left me enough conceit to believe that I can occasionally see the indicated remedy. I repeated that drug in ascending doses until I reached sixty drops at the dose, and still no appreciable result could I note. All this dosage was with a tincture made by one of the most reliable homœopathic pharmacies in the world, bar none, and the same one, too, from which I had gotten that magnificent tincture that did the fluid extract up in one round with a solar plexus blow. My case hung fire on this "reliable" tincture, and at the nearest drug store I procured some of the fluid extract, made by the same firm whose other drug had proved so rankly unworthy, and this new fluid extract in two-drop doses did the work that I could not get out of sixty drops of a specially-prepared tincture. You see, therefore, that there are several sizes of shoes here, and they will fit on the feet of both the so-called refined homœopathic pharmacist, and on his alleged crude and bungling old-school *confrère*. Please, please, at this point do not

let some one unthinkingly remark, Why did you not give your drug in a higher potency? I am not discussing just now the potency question, but simply one of pharmacy. But, simply as a matter of experiment, suppose I had given a potency run up from either the ineffective tincture or the fluid extract, I opine it would take the imagination of a Jules Verne to see the resulting therapeutic action. What effect could one logically expect from potencies made from such absolutely useless drugs in their crude form? I fear it would take more than the wonderful and mysterious dynamis to do anything with such drugs. It would need a special creative act, unknown to us poor mortals, to make something out of nothing. Possibly, however, some thinking high potentist may see here a reason why *his* drugs fail. They may start the original potencies from just such worthless mother-stock as I have been endeavoring to illustrate.

One factor of drug failure at least lies in the experiences I have just cited. A solution of the trouble will only come when we understand the cause of these only too obvious variations in drug strength. Do reliable pharmacies furnish these unreliable medicines to the profession and public wittingly and with malice aforethought? My answer is most emphatically, No! They are as much in the dark as to the efficacy of the drugs they dispense as are the doctors who dispense or prescribe them with a confidence borrowed from a knowledge of the reputed excellence of the drug on the one hand, and their belief in the honesty of the pharmacists on the other. I think the whole medical profession would be a unit on one thing at least, and that is in a demand for reliable drugs, and of absolute and unequivocal condemnation of any attempt to foist upon either the profession or the laity drugs not up to the highest possible standard. The pharmacist who would wittingly sell a drug of known inactivity, when one of pronounced activity is wanted, is beyond the pale of consideration in a paper of this kind. I can only say that no greater fraud is possible than that, and there are certainly circumstances in which such action is even worse than murder. Such offenders should be drummed out of town, and then hung and quartered, exposed to disease, and then given the innocuous "medicines" they have sold to other sufferers.

The lack of efficiency lies, then, not with the honest pharmacists, but in the drugs themselves. They vary in strength from perfectly natural causes. In the gathering of plants, flowers, leaves, roots, etc., to make tinctures and fluid extracts, the utmost care is observed as to the time of gathering, the apparent perfection of the parts of the plant to be employed, in manufacturing the drug, and, in fact, every single precaution is more than anticipated, in order to secure the best possible purity and evenness of strength. With all this care, however, the drug made is apparently, for some inexplicable reason, afterwards discovered to be therapeutically inoperative. Why is this? The reason is perfectly obvious, if we accuse nature of not always being in the same mood. In other words, seasons are not alike. Some have more rain, more sunshine, more wind, more minerals in the soil, less nutritive material in the earth. In point of fact, nature sometimes parallels in her wild plants used for medicines the effects she produces when a plant has been domesticated for several generations. It is a fact well known that plants of known lethal qualities when cultivated soon lose their power of producing death, soon lose all their so-called drug efficacy, their inherent qualities, although the general appearance may be retained, or even improved upon by the process of cultivation and care. Examples of this kind will be found in the foxglove, in the wild turnip, the wild potato, the cucumber, the marigold, etc. If the apparently more favorable environment of careful cultivation can render a formerly toxic plant innocuous, or practically so, one can easily understand how the vicissitudes of season can alter the essential quality and character of a presumably medicinal plant. The pharmacists are not to blame, therefore, for this unevenness in power displayed by drugs, but nature is. Nature's forces are changeable infinitely, within a certain limited scope, and while she apparently repeats her plant work every year with photographic perfection, certain underlying laws of plant growth and development vary from season to season.

In a vague sort of a way, the profession, as well as the drug-makers, have recognized this factor as a cause of inefficiency, and some have reached out towards alkaloids as a remedy for this irregularity in medicinal power. Possibly herein lies the secret of the growing tendency toward alkaloidal medicines.

While this is, perhaps, a step in advance, so far as certain specific uses of a drug is concerned, the truth of alkaloidalism is only a partial one at best, and we are only on the threshold of the initial knowledge on this subject. While a study and use of alkaloids will undoubtedly precisionize our knowledge of drug power, and, in many instances, we will be able to get more out of a drug than formerly, we must ever be on the alert to find new alkaloids in old drugs, and we must be sure we have found the alkaloid that is doing the effective work. There is a danger in alkaloidism. We must not forget that the whole drug in its purity is a powerful therapeutic power, different in action from the isolated principle, and, if we were to adopt alkaloidism and drop full-drug prescribing, we should probably lose more than we would gain, so far as our ability to control symptoms, states and conditions in disease is concerned. Besides, if the whole plant from which the alkaloid was derived was of the inefficacious kind, the alkaloid would be as ineffective as its drug parent. The whole secret of general drug efficacy, whether of fluid extract, tincture, alkaloid, or what not, is, that drugs shall be of standard strength before they are dispensed to the profession.

An effort in this line has already been inaugurated by a Western firm, who assays for alkaloids certain of its drugs, and guarantees its drugs to be of a certified strength. It has ceased to depend upon the eye as a means of determining whether a given drug is good therapeutically or not. I understand that this firm was led to this experiment by finding a whole cargo of cannabis indica, that looked the very perfection of plant life, when reduced to fluid extract form, to be absolutely of no value when compared with an old supply of the drug they had on hand. The inefficiency of the drug was discovered by testing it on animals, and the efficacy of the old drug was tested in the same way. The estimation of drug strength is certainly a move in the right direction, and in one way or another ought to be adopted by every drug manufacturer. We have a right to demand effective rather than elegant pharmacy, although we want both elegance and efficacy. We have a right to expect a reasonable and uniform degree of strength. We ought not to find that a drug given to an individual in the accustomed dosage of that drug needs to be increased four- or five-fold be-

fore an effect is observed, and, on the other hand, find a drug so potent that a minimum amount gives unexpected results, although we are very willing to take the latter alternative if we cannot get uniformity.

Another firm has lately lauded the wonderful results achieved from green plant tinctures. They, too, realize that drugs are not of uniform strength. But, while certain tinctures made from green plants are apparently of more service therapeutically, we must learn more about the effects of chlorophyl before we unequivocally endorse this departure from the ordinary methods of pharmacy. Certain it is, without special investigation, that the rule of making all plant drugs in the green tincture would not be of universal application.

There are many, very many, effective drugs made from dried plants, and it is reasonable to suppose that some plants have their medicinal virtues increased by the very process of drying. Possibly new alkaloids develop. Every drug is a law unto itself regarding the manner of its preparation, and as to whether its therapeutic value is enhanced by this, that, or the other method of preparation. Pharmacists must first individualize, before they generalize, and must not make arbitrary classifications of the methods of preparation until experience has demonstrated beyond peradventure the best, and consequently the only, method of rendering a given drug capable of doing the work of which it is proven that drug is capable of doing. The truth of the matter is that the most learned in pharmacy do not know any too much, any more than do we as physicians. True pharmacy I believe is in its swaddling clothes so far as the preparation of absolutely reliable drugs is concerned, and pharmacy will remain in the stage of infancy until it ascertains a method of furnishing the profession and laity with drugs of proven value. The method of determining that a given drug is a good one simply because it has been gathered at the proper time of the year, that it smells like a good drug, and has, in fact, all the naked eye appearances of a perfect plant, must be abandoned. For this method must be substituted either chemical tests, to determine the alkaloidal and other strengths, or by direct experiments upon animals to determine the drug's power to produce the so-called physiological or pathogenetic effects, and this investigation must be made for every medicinal sub-

stance, whether mineral, vegetable, glucosidal or alkaloidal. This examination must be made every time a drug is freshly made. In this way we will soon have effective drug weapons, and the honest pharmacist will not unwittingly make fools of the physicians who prescribe his drugs, and the honest doctor will stop his attacks on the medicine makers, and the pharmacist will teach the doctors much by the discovery of unexpected drug effects, and the doctor will thank the pharmacist as a worthy co-worker for humanity's sake.

It is doubtful whether we dare ask our homœopathic pharmacists to prove a drug on the healthy before they let the medicine go off their store shelves, although this would be the ideal method. We can, however, demand that the drug be not judged to be good because it looks all right. We can demand that it be tested chemically or upon animals, in order to demonstrate that the drug is an active one. I think it may be assumed that a drug showing alkaloidal strength has the power to produce the symptoms of that drug when given to the healthy. The principal thing we want to know is that the drug is not practically inert. We must certainly demand that drugs from which potencies are made shall have a demonstrated power in the tincture.

Perhaps I have gone too far afield in attempting to discuss only a single factor for our failures with drugs. I cannot but believe, however, that a recognition of this one single factor will be of service to us in our fight with disease. Drugs are our tools, and if there is one workman on the face of the globe who ought to have perfect tools it is the man who fights disease and death. Medicine has made much progress in the last two decades, in diagnosis, in bacteriology, in hygiene, in the prevention of disease, and we shall add new and deserved laurels to her crown if she can but improve her drug armamentarium up to a practical and uniform standard of usefulness. May the happy day soon come when we can give a drug with a feeling that it will do the work we intend it to do in our efforts to cure or ameliorate the horrors of disease. Let us have uniformly reliable drugs.

MERCURIUS IN COLDS.—Pains in the limbs, sore throat, sore eyes, tooth-ache, otalgia, painful diarrhœa, or even dysenteric stools.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

NEW YEAR'S GREETING.

WE were prepared to indulge in some eloquent reflections upon the wonderful progress made in the science of medicine in the last years of the nineteenth century, and to point with professional pride to the bright prospects of further advancement in the coming twentieth, when it struck us that as A.D. 1 marked the beginning of our present era, the first century was not completed until the close of the year A.D. 100, and that therefore the second century did not commence until A.D. 101, and that, consequently, we could not greet the twentieth century until A.D. 1901. With this conviction forced upon us, we are obliged to acknowledge that anything at the present time relating to the much-spoken-of twentieth century could justly be regarded as premature, and we are compelled to withhold our lucubrations until they become more timely. We therefore content ourselves with wishing our readers a Happy New Year. May the dawn of A.D. 1900 find them in a condition in every way favorable to completing in a worthy manner the work of the old century, and prepared at its close to add the lustre of their own achievements to the promised glory of the new.

HEALTHY INVALIDISM.

EVEN if it is not the beginning of the twentieth century it is the middle of winter, according to the almanac, whose testimony is substantiated occasionally by the thermometer; colds are common, and it is time for the usual wild talk about "the La Grip," as Mr. Dooley has it.

So long as two weeks ago an item appeared in the news-

papers that la grippe was upon us again in an unusually severe form. Fortunately the rumor proved to be unfounded, and the pleasant weather, with the pleasurable excitement of the pre-Christmas season, prevented the ill-advised suggestion from producing its natural effect. Much harm is done in this direction by the daily press. The ambition to have exclusive news often results in presenting to its readers items which are exclusively news and not facts. Being entirely impersonal—a body without a soul—it is not deterred by the terrors of the timid, nor by the danger of increasing disaster, from emphasizing and exaggerating facts about which as little should be said as possible. But our profession is not without blame in the matter. It is not difficult to find physicians who, for the empty honor of appearing in print in an interview with some reporter, are ready to tell all they know, and sometimes more, about the prevalence of an epidemic, its symptoms, dangers, etc., or even to give premature birth to an abortive idea as to some supposed new disease wherewith to terrify the public—all usually with a decided leaning to the sensational and exciting.

With the profoundest respect on our part for the medical profession, ideally, the question has often of late presented itself to our mind whether it has not fallen, unwittingly, we hope, into the habit of hypnotizing the public and offering suggestions which tend to create a demand for its services when natural causes prove insufficient. Some individual members are well known by their colleagues, and even by their patrons, as alarmists, who, by their influence and by their utterances, diffuse through the community an atmosphere of expectancy which renders it peculiarly susceptible to the inroads of disease.

While this holds true as to the acuter forms of disease, we think the profession at large, in its laudable efforts at prophylaxis, is a very active factor in the production of that vast army of healthy invalids which surrounds us. It may be one of the mysterious ways of Providence to protect and promote the interests of those who have for so many ages been recognized as the chosen instruments in carrying out its decrees. How many apparently healthy persons do we not find living, as it were, by the will of their physicians—not venturing to feel well unless justified in doing so by the results of a previous examination

at their hands? It is a nice question, only to be decided by each individual physician in how far he is bound to share his knowledge of remote possibilities with his patients. We have seen individuals living in daily terror of some catastrophe to themselves, the remote possibility of which has been communicated to them by their medical adviser in a burst of confidence. A Damocles' sword is fixed firmly and securely over many a head, though made seemingly to hang by a thread by the diagnostic refinement of the physician. We are in danger of developing a race of valetudinarians. Whether a life is worth living which can only be preserved by a painfully exact method, enforced by a fear of death, depends, we take it, upon disposition and temperament. Absolutely perfect health falls to the lot of but few, but that is no reason that the large remainder must be tormented with gloomy forebodings of what may possibly happen, especially if these fears are to be emphasized and kept constantly before the mind by regulations and restrictions. To the physician the making of a diagnosis and prognosis becomes so much a matter of routine that he is apt to forget what these mean to the individual patient, and many regard it as a duty to communicate them in all cases to the one concerned. Let such be compelled, in their own case, to arrive at a diagnosis of a serious disease with its doubtful prognosis, and we will find the vast majority perfectly willing to exchange for certain knowledge, which brings no comfort, doubt, or even complete ignorance, upon which they can build a hope.

We know that sickness is not a nothing, to be gotten rid of by a foolish denial of its existence, but who can deny that trifling ailments can be changed into serious ones, capable of permanently ruining the health, or even of causing death, by suggestion from within or from without? The true physician should strive to turn his patient's thoughts away from his disease, while he himself is concerned in removing it by all means at his command. A man may be as old as his arteries, but a man—the true man—is as well as he feels. A condition of unhealthy well-feeling is surely preferable to a condition of healthy invalidism.

“The mind is its own place :
Can make of heaven a hell, of hell a heaven.”

THE DEATH OF DR. ISAAC G. SMEDLEY.

"DR. SMEDLEY was killed at Bryn Mawr, in attempting to board a moving train, leaving at 1.18 P.M." This startling message carried sorrow and distress to those who knew Isaac G. Smedley, and tore the heart-strings of those who loved him.

With his tragic life-ending the light of the most brilliant and accomplished operative gynecologist of Philadelphia went out.

As a gynecologist Dr. Smedley's reputation and success was founded upon his accurate, clear-cut, comprehensive judgment, which was based upon knowledge acquired by years of patient, indefatigable toil in clinical work; and to his consummate mastery of operative technique, combined with a fearless surgical initiative, which was governed by true conservatism. These brought results gratifying to himself and to those placing their lives in his keeping.

As a physician, he recognized that avoidable ignorance was an unworthy return to those who trusted him, and he was unceasing in his efforts in their behalf.

As a man, he was splendidly virile, being characteristically gentle, yet resolutely firm when occasion demanded. His benevolence verged upon munificence.

As a friend—he, who knew him as such, grappled him to himself with imperishable bonds.

As a school, we are appalled at his death, and know not how to fill his place, and must await for time to develop his successor. As his associates, we mourn the loss of the true friend, the trusted counselor and the boon companion.

The Omnipotence has removed him from us, and it is ours to humbly commend the soul of our brother into the hands of our Most Merciful Saviour, beseeching that it may be precious in His sight.

"We live in deeds, not years; in thoughts, not breaths;
In feelings, not in figures on a dial.
We should count time by heart-throbs. He most lives
Who thinks most, feels the noblest, acts the best."

—Festus.

GLEANINGS.

THE OPERATIVE TREATMENT OF TYPHOID PERFORATION.—Keen, of Philadelphia, summarizes his views on the operative treatment of typhoid perforation as follows :

1. The surgeon should be called in consultation the moment that any abdominal symptoms indicative of possible perforation are observed.

2. If it be possible to determine the existence of the pre-perforative stage, exploratory operation should be done under cocain-anæsthesia before perforation, shock and sepsis have occurred.

3. After perforation has occurred, operation should be done at the earliest possible moment, provided,

4. That we wait till the primary shock, if any be present, has subsided.

5. In a case of suspected but doubtful perforation, a small exploratory opening should be made under cocain to determine the existence of a perforation, and if hospital facilities for a blood count and for immediate bacteriological observation exist, their aid should be invoked.

6. The operation should be done quickly, but thoroughly, and in accordance with the technic already indicated.

7. The profession at large must be aroused to the possibility of a cure in nearly, if not quite, one-third of the cases of perforation, provided speedy surgical aid is invoked.—*Phila. Med. Journal*, Nov. 4, 1899.

F. Mortimer Lawrence, M.D.

CANCER OF THE STOMACH.—The following rules are suggested upon which to base a positive diagnosis of cancer of the stomach :

1. If particles of tumor are found (in the wash-water or in the tube) which under the microscope reveal the characteristic picture of a malignant growth.

2. The presence of a more or less large tumor with an uneven surface, belonging to the stomach and associated with dyspeptic symptoms.

3. The presence of a tumor associated with frequent hæmatemesis.

4. Constant pains, frequent vomiting, isochymia, emaciation—all these symptoms being quite permanent and not extending over too long a period of time (six months to a year).

5. Tumor and isochymia.

6. Emaciation, isochymia, presence of lactic acid.

7. Constant anorexia and pains, not yielding to treatment, accompanied by frequent small hæmorrhages of coffee-ground color.—M. Einhorn, in *New York Medical Journal*,

F. Mortimer Lawrence, M.D.

FUNCTIONAL CARDIAC MURMURS.—Real functional heart murmurs, due to the faulty action of the valves or muscle without pathological change in the organ, are, according to Jacobi, much rarer than formerly supposed. Recent studies of the myocardium show that its changes may sometimes give rise to

murmurs. When the child's heart is developing the cavities enlarge, but the wall of the heart does not always grow thicker. During this period murmurs may be heard, and they would appear to be due to myocardial insufficiency at certain times, constituting an organic, not functional, defect.—*Boston Med. and Surg. Jour.*, Sept. 7, 1899.

F. Mortimer Lawrence, M.D.

NEPHRITIS COMPLICATING GASTRO-ENTERITIS IN CHILDREN.—Dr. Kopik, noticing that nephritis frequently complicates gastro-enteritis in children, at least in serious cases, calls attention to three symptoms which should attract the attention of the physician :

1. Restlessness, incoercible and persistent vomiting, and cutaneous œdema. Restlessness of uræmic origin is characterized by its persistency and by its alternating with periods of stupor.

2. Vomiting of renal origin is not affected by washing out the stomach nor a strict diet, distinguishing it from that of gastric origin.

3. The œdema is less apparent than in Bright's disease in adults, and it may be overlooked if not sought for. The anterior parts of the lower limbs and dorsa of the feet are the places of predilection. To dent the flesh one must press down forcibly.

Children with such symptoms present albuminuria, casts, renal epithelia and red blood-corpuscles. The quantity of urine is also more or less diminished. The outlook is favorable if the toxins be eliminated by energetic and appropriate treatment. Therapeutically, he advises washing out the stomach and rectum several times a day with a solution containing 4 per cent. of sodium chloride and 3 per cent. of sodium carbonate, leaving some in the intestine to be absorbed to stimulate the kidneys. In more serious cases he injects two hundred ccms. hypodermatically. During the whole period the child is fed on albumin-water diluted with lime-water. Internally he employs the subnitrate of bismuth in large doses; all other intestinal antiseptics only irritate.—*La Settimana Medica*, No. 37, 1899. The importance of watching the kidneys in intestinal affections, and especially in children, has been brought out of late years. If the urine of children with diarrhœas be examined it will be noted that in a large number it is complicated by albuminuria of more or less severity. This, of course, usually disappears soon after the primary trouble is ended. I lost a little child out of my own family from a chronic diffuse nephritis, following a very severe attack of entero-collitis, at the age of three months. She gradually grew weaker, and refused to learn to eat solid food or to walk, though her teeth erupted naturally and at the proper time. Finally she grew so weak that she was unable to sit up, became emaciated, with œdema of the extremities and face, and finally died of progressive heart-failure at the age of 2 years, pale, wax-like, emaciated, full of torturing pains, a prey to anxiety, restlessness, horribly agitated and restless of nights, turning and twisting, never resting ten minutes in one position during the nightly aggravations. Her disease was not recognized by several good diagnosticians nor by myself for some time, for we were everlastingly searching for rickets. "Morbus progrediens usque mortem, spes nulla, therapia nulla."

Frank H. Pritchard, M.D.

A CASE OF COMA IN CANCER OF THE STOMACH.—Dr. Frederik Groen observed a woman of 53 who was sent to the University Hospital in Chris-

tiania, Norway, as suffering from hysteria. She was profoundly somnolent, which soon became a pronounced coma. Death followed about one day after entering. The necropsy revealed a cancer of the stomach which had not been suspected either from physical examination or from the rather fragmentary history which her husband furnished. The other organs were perfectly normal, and the urine contained neither sugar nor albumin. The writer calls attention to the possibility of coma accompanying cancer of the stomach, which variety Senator has described as coma dyscrasicum. He regards it as due to an auto-intoxication by abnormal products in the blood, possibly acetone.—*Norsk Magazin for Lægevidenskaben*, No. 9, 1899. Prof. F. Riegel—*Die Erkrankungen Des Magens*, p. 792, Vienna, 1897—asserts that the coma of carcinoma of the stomach is in many points similar to that of diabetes. The patient becomes apathic, later soporous, wholly somnolent, and he does not react to loud calling. The breathing becomes labored, deeper, the respirations loud and easily heard, the pulse very small and frequent, and with these symptoms the fatal ending soon follows. In some cases epileptiform spasms have also been noticed.

Considerable acetone and diacetic acid are excreted and found in the urine; the alcalescence of the blood is diminished. Whether the coma be due to a specific poison formed by the carcinoma or an acid poisoning is not yet known.

Frank H. Pritchard, M.D.

ACUTE POISONING BY LYSOL.—Dr. Bohlen's stable-hand found a bottle containing lysol in the doctor's carriage which he thought was brandy, and without waiting to inquire further drank about ten grammes of it. He complained of burning in the mouth and throat, and after stumbling about for five minutes fell into a deep sleep from which he could not be awakened by any means. Apomorphine subcutaneously and high rectal irrigations brought about vomiting and several stools with such improvement that in two hours he could with aid go to his bed. He took also about an ounce of sodium sulphate in two quarts of water. The next day he was in a condition resembling that following a spree—a "katzenjammer." Appetite and a complete recovery soon followed. No albuminuria at any time was demonstrable.—*Deutsche Medicinische Wochenschrift*, No. 30, 1899.

Frank H. Pritchard, M.D.

PERFORATING ULCER OF THE ŒSOPHAGUS.—Dr. Lindsay reports the case of a man of fifty-nine who, after drinking a bottle of beer, was seized with violent pain in the epigastrium and vomiting. The urine contained some albumin and sugar. In the right pleural cavity an effusion was to be detected. Soon emphysema began to develop about the eyelids, then on the left side of the face, neck and chest. An ulcer of the stomach was thought to have perforated into the lung, though the previous history of the case gave no hint. At the necropsy a non-carcinomatous ulcer, which probably was of syphilitic origin, was discovered in the Œsophagus near the cardiac end of the stomach. This had perforated into the posterior mediastinum, where an abscess was found between the descending aorta and the Œsophagus which had ruptured into the lung.—*Dublin Journal of Medical Science*—*Berliner Klinische Wochenschrift*, No. 39, 1899.

Frank H. Pritchard, M.D.

A CASE OF MULTIPLE STENOSING INTESTINAL TUMORS OF TUBERCULOUS NATURE; TRIPLE RESECTION OF THE INTESTINE WITH A FAVORABLE RESULT.—Dr. Ali Krogius observed a woman of thirty-three years who three months before had suffered from symptoms which pointed to a stenosis of the intestine, and which were by external examination revealed to be due to two tubular tumors which were fixed in the ileo-cæcal region. A diagnosis of intestinal tuberculosis was made. The operation revealed two growths of the small intestines, which were removed by resection and circular suture of the intestine, together with a third, which involved the lower portion of the ileum, cæcum and the neighboring portion of the ascending colon. This was also extirpated at the same time by resection of the affected part, when the ends of the bowel were united by a Murphy button. The further course of the case was very good. While under observation at the hospital, signs of an affection of the gall-bladder appeared two months after, and forty gall-stones were removed by operation. Microscopic examination of the extirpated portions revealed them to be due to localized tumor-forming tuberculosis.—*Nordiskt Arkiv Mediciniskt Arkiv*, Hft. 4, 1899. According to Eichhorst (*l. c.*), the seat of this affection is usually in the lower portion of the ileum. He calls attention to the symptomatic value of attacks of colic appearing paroxysmally in the right iliac region, and particularly in the first hours after midnight; they appear with a certain degree of regularity, and this region is very painful to pressure.

Irregularity of the evacuations is another characteristic symptom: either obstinate constipation or diarrhœa, which is controlled with difficulty. A perforation or a hæmorrhage may follow or complicate. The former may give rise to a localized or a general peritonitis. Stenosis or ileus may result.

Frank H. Pritchard, M.D.

CARCINOMA OF THE KIDNEY WITH MULTIPLE GLANDULAR METASTASES.—Dr. Treyer reports the case of a young man of twenty years who died after suffering for six months from an enormous carcinoma of the left kidney, with numerous and extensive metastases in the various glands. From the character of the kidney tumor and the very slight degree of albumin at first, and later none, the absence of morphological elements in the urine, the quite uniform increase of leucocytes in the blood, the decrease of hæmoglobin and red blood-corpuscles during life, pseudo-leukæmia had been diagnosed.—*Muenchener Medicinische Wochenschrift*, No. 44, 1899. Osler places a great deal of dependence on hæmaturia; and particularly if casts of the pelvis of the kidney or ureters be passed, and progressive emaciation. Pain is an uncertain symptom.

Frank H. Pritchard, M.D.

PSEUDO-APPENDICITIS.—Prof. Nothnagel asserts that hysteria may bring about a false hysteric appendicitis, as well as a peritonitis. A man, twenty years of age, was suddenly, without apparent cause, seized with severe colicky pains in the right illiac fossa, sensitiveness in this region, where a tumor of the size of a walnut was thought to be palpable; besides, there was hyperesthesia in the right sacro-lumbar region, and sensitiveness of the sacrum and lowermost lumbar vertebræ. The patient was transferred to the hospital, where he lay for fourteen days without any change in the symptoms, and during the whole time was without fever. He was discharged, but he

returned and demanded an operation, for which the appendix was extirpated, though the parts, both extra- and intra-peritoneal, were found wholly normal, together with the vermiform appendix, which was removed. The symptoms disappeared and for two years he was well, when he was affected with continuous and severe pains in the same region. Objectively he had a facial expression of suffering, he was anxious with regard to the outcome of the disease, and made confirmatory measurements of his temperature. He kept his right leg flexed at the hip and knee, and extension pained him. There was noticeable sensitiveness to pressure in the right fossa, considerable cutaneous hyperæsthesia, but nothing pathological was detected on deep palpation. This hyperæsthesia was noted higher up on the right side. The reflexes were augmented and there was concentric narrowing of his visual fields. Temperature normal. He was cured in fourteen days by application of the faradic brush.—*Hospitalstidende*, No. 42, 1899. Osler states that hysterical peritonitis has deceived the very elect, as almost every feature of genuine peritonitis, even the collapse, may be simulated. The onset may be sudden, with severe pain in the abdomen, tenderness, vomiting, diarrhoea, difficulty in micturition, and the characteristic decubitus. Even the temperature may be elevated. There may be recurrence of the attack. A case has been reported by Bristowe in which four attacks occurred within a year, and it was not until special hysterical symptoms developed that the true nature of the trouble was suspected.

Frank H. Pritchard, M.D.

DIAGNOSIS OF TUBERCULOSIS IN NURSELINGS.—Dr. W. Bulius has studied, from twenty-seven cases of nursing children from Professor Heubner's clinic in Berlin, the interesting and difficult subject of tuberculosis at this age. The little patients varied in age from four to twelve months, and of them twenty-four were examined post-mortem. Every one who has studied this subject knows how difficult it is to make a diagnosis of tuberculosis at this age. He has based his work on these carefully observed cases, and has not gone into the literature.

In all these the bronchial glands were the seat of caseous or purulent foci, and as the tuberculous processes were most pronounced in these glands, he assumes a primary infection should always be sought here.

From these, periglandular pneumonias originate, transplanted by continuity; or, what is most frequent, the softened foci in these glands break into the bronchi, to be followed by extensive, acute tuberculous pneumonias.

If these caseously degenerated glands perforate into the blood-vessels an acute miliary tuberculosis results, which is not limited to the lungs, but also affects the liver, spleen, etc. Extension may also occur from involvement of the peribronchial lymph-tracts or paths.

This lymphatic tuberculosis is the most frequent in the first year of life, bringing about caseous processes, which are the most usual and more frequent at this age than the miliary form.

In about forty per cent. there were cavities in the lungs.

In the history of the case not only the health of the parents, but also that of other persons with the child should be inquired into.

The general condition is in relation to the intensity of the disease.

The child is dull, relaxed, with a swollen face and a pale, cyanotic com-

plexion. The change of humor is particularly striking: friendly and cheerful children become morose and peculiar; boisterous ones become quiet and apathetic. At times they become excited and violent, at others tearful and frightened. If a seemingly slight bronchitis be accompanied by strikingly pronounced restlessness, one should be on one's guard; and still more suspicious is it if a child, apparently without reason, becomes ill-humored and strangely cross. Violent acute tuberculosis is, of course, accompanied by great and sudden loss of weight. In the more chronic ones the body weight for a long time remains unaltered, then slowly decreases. Digestive disturbances are very rare.

Nursing children, who gradually and steadily diminish in weight in spite of a normal appetite and stools, are strongly to be suspected of being tuberculous. Spasms are frequent in these children. If tetany, rickets and intestinal catarrhs can be excluded, repeated attacks of spasms point to tuberculosis. The temperature has no characteristic peculiarity; *there is no hectic fever curve*. Many cases have no fever at all. Scrophulides, or spina ventosa, may appear to confirm the diagnosis; numerous petechiæ on the abdomen, if sepsis can be excluded, are suspicious. Outbreaks of furuncles and peculiar serpiginous eczemas are noted as very frequent. Glandular enlargements, except of the supraclavicular regions, are of no diagnostic value. Enlargement of the mesenteric glands is of certain pathognomic value.

There is a cough which reminds one of whooping cough, with venous stasis; the veins of the neck and face become prominent and the face puffed up. No expectoration; never any hæmoptysis. The respiration is very rapid and forced, with dilation of the nostrils and play of the *alæ nasi* and retraction of the pit of the stomach. In spite of this the physical signs are few. If heart disease can be excluded, this sharp contrast between the dyspnœa and the objective findings is always suspicious if the thorax be not very rachitic.

Cyanosis of the feet and extremities and face are frequent. Frequent collapsive attacks in children who are neither weak nor emaciated are suggestive. No albuminuria. If present with casts, it would rather be against such a diagnosis.—*Hospitalstidende*, No. 41, 1899.

Frank H. Pritchard, M.D.

OTHER VARIETIES OF TUBERCULOSIS IN NURSELINGS.—Dr. W. Bulius asserts further that bronchial tuberculosis is frequently without symptoms. If a child thrive poorly without rickets or signs of digestive disturbances, it is often a symptom of tuberculosis. If there have been consumptives in his surroundings it would awaken suspicion. If he have a pertussis-like cough, with pronounced bronchial respiration in the inter-scapular region, a diagnosis of tuberculosis of the bronchial glands would be probable, though not absolutely certain.

Acute tuberculous pneumonia sets in with fever, cough and dyspnœa. The fever rises, as a rule, and continues high until death. The cough in the beginning is hard and dry, later to become loose. The difficult breathing is very severe. The stethoscopic findings at first are not different from those of a croupous pneumonia, but the fine fugitive râles which in pneumonia disappear at the height of the disease, in tuberculous pneumonia *continue unchanged*. Such a sign is very suspicious, particularly if percussion reveals no tendency of the dull areas to clear up, the respiration takes on an amphoric character,

and the râles remain clicking. At the same time the child rapidly emaciates and death follows even in two weeks.

Miliary tuberculosis often appears very acutely in an apparently healthy nursingling, like a flash of lightning from a clear sky. The child suddenly becomes ill-humored, irritable, its look anxious and restless. The breathing becomes rapid, with play of the *alæ nasi*, which may be grunting and irregular. Stethoscopically no dullness is found, and perhaps bronchial sounds. Cyanosis of the feet, extremities and face set in. The child becomes feverish, with short and distressing attacks of coughing. There is an enlargement of the spleen, but no disturbance of digestion. Slight œdema and collapsic attacks appear quickly, and the child, who possibly before the disease was well, rapidly passes on to death.

Those cases which take on a septic character are especially difficult to diagnose. The cyanosis and dyspnœa here attain the highest grade, in spite of the negative pulmonary findings. Differentially sepsis must be excluded, of which sopor, diarrhœa and albuminuria are pathognomonic, and are nearly always present in sepsis in nursinglings.

Still more difficult is a diagnosis of a "closed" tuberculosis where the interstitial tissue alone is involved. These cases at times are overlooked by the most experienced observer. The child is the prey of a pure atrophy. The experienced clinician will see a few signs which will be of service. The swollen, pale and cyanotic face of the tuberculous child is far different from the atrophic child's face of an old man—*oldingeagtige Ansigtstraek*; the morose, irritable humor of the tuberculous child is characteristic. Another striking feature is that the child emaciates in spite of a good appetite and ideal stools. To this are added periodically-appearing broncho-pneumonic attacks of an acute or subacute course, so that a diagnosis during life may be made. The course of "closed" tuberculosis is very long, and months may pass before a broncho-pneumonia or a miliary deposit may force the skeleton-like little body to succumb.—*Hospitalstidende*, No. 41, 1899. In examining such patients, let us not forget that there is such a thing as a chronic nephritis, a Bright's disease, even in nursinglings and little children. The swollen and pale face of the tuberculous child may be simulated by the chronic nephritic. Prof. Heubner, of Berlin (*Die Chronische Nephritis im Kindesalter*), has directed our attention to this disease in children.

Frank H. Pritchard, M.D.

WEIL'S DISEASE, OR ACUTE INFECTIOUS ICTERUS.—Dr. Woldemar Richter in reporting a case of that curious affection, Weil's disease, or acute infectious icterus, remarks that it began like a typhoid fever case in the second week, and remained four days with continuously high fever, confusion of the senses and somnolence, as well as painfulness of the region of the spleen and the right ileo-cæcal region.

Against the acceptance of typhoid there were labial herpes, the clay-colored stools, the rapid rise of temperature and its final uniform fall. There was an absence of splenic enlargement and roseola. It appeared at first with pulmonary symptoms which led him to think of a pneumo-typhoid, but at the same time there were characteristically severe pains in the muscles. On the sixth day of the disease the extreme icteric coloration of the whole body, 2, the muscular pain, 3, the acute enlargement of the liver, 4, the characteristic

stools, with the mentioned phenomena of a general febrile affection, the extravasations of blood beneath the skin, and later the muco-sanguinolent appearance of the sputum and stools and the appearance of albumin in the urine, led to a diagnosis of Weil's disease.

A serious seizure of anuria in consequence of acute hæmorrhagic nephritis and uræmic catarrh of the colon followed, with death from uræmia. after fifty-five hours, this latter produced by cardiac paralysis, with beginning œdema of the lungs. There was no œdema around the ankles nor eyes. The urine was of a brownish and beer-like appearance, contained three-fourths per cent. albumin, blood pigments and biliary coloring matters; its sp. gr. was 1020, and in the sediment there were numerous epithelial, granulated and bile-tinged casts. Necroscopically there were found: 1, infectious icterus; 2, bilateral hæmorrhagic nephritis; 3, œdema of the lower lobes of the lungs; 4, hyperæmia of the mucous membranes of the larger bronchi, stomach and colon; 5, labial herpes; 6, petechiæ.—*Deutsche Medicinische Wochenschrift*, No. 43, 1899.—Eichhorst—*Lehrbuch der Praktischen Medizin Innerer Krankheiten*, 1899, p. 890—states that this affection is a peculiar form of infectious icterus which mostly is noted during the summer months. It begins with chilliness or chills, followed by a temperature of 40° C., and even above that. The patients complain of muscular pains, especially in the calves of the legs, become somnolent and delirious, and icterus sets in, with enlargement of the liver and *spleen*. The urine contains bile-pigments, generally albumin, and not rarely blood and renal casts.

The stools are not infrequently free of bile. In one or two weeks the temperature gradually falls, but recurrences often occur. The disease is often met in butchers, though it has been noted after swallowing sewer-water and after bathing in the Danube near Ulm. The genetic micro-organism is unknown. Necroscopically cloudy, swelling and fatty degeneration of the various organs has been found. A recovery is the rule. Osler—*Practice of Medicine*, 1892, p. 265—says that a few cases have been reported in this country (Lanphear). He states that it sets in abruptly, and that marked remissions occur characteristically. Jaundice is an early symptom. Goodno—*Practice of Medicine*, Vol. I., p. 451—states that the fever rapidly sets in, rises quickly to 104–105°, and remains there until the fifth to the eighth day of the disease, when it begins to subside, gradually becoming normal on about the twelfth day. The pulse, which does not keep pace with the fever, ranges from 100 to 110 per minute. It would have to be differentiated from a typhoid, a malarial intermittent and remittent, a pneumonia, an osteomyelitis, a congestive attack in an old kidney disease, etc.

Frank H. Pritchard M.D.

THE DISAPPEARANCE OF PYLORIC CANCERS.—Dr. Tuffier, of Paris, in a case of Dr. Demoulin's, after a posterior gastro-enterostomy, where the operation was done for a cancer of the pylorus, and the tumor had wholly disappeared after the operation, states that he has observed such tumors to retrocede and finally disappear. It might be thought that consequently they were of inflammatory origin, and one might be misled into taking a more hopeful view of the case. Yet one should not forget that this may be due wholly to retraction of the tumor beneath the false ribs. Professor Porier at the discussion on this report, which was made at a recent meeting of the Société de Chirurgie of Paris, points out that the disappearance of a tumor may be due to a regres-

sion of the neoplasm, a retraction of the tumor, or, lastly, to a neoplastic invasion of the gastro-hepatic omentum, which, retracting, draws the growth up beneath the false ribs. Thus a tumor which three months before was palpable in the umbilical region now may be scarcely appreciable under the short ribs. M. Schwartz said that he has seen a woman with a pyloric cancer who three or four weeks after a gastro-enterostomy presented no growth at all. He thought the neoplasm of inflammatory nature, but having seen her recently he has been able to detect nodes in the omentum which were manifestly cancerous. In this case there was merely a retraction of the tumor towards the hilus of the liver.—*La Semaine Médicale*, No. 46, 1899. A medical friend of mine in a neighboring town related me a case of cancer of the pylorus where, without any operation, the tumor *apparently* disappeared. He attributed it to a breaking down and sloughing out of the surroundings, as it were. Though no metastasis followed, yet the patient remained in a miserable condition for a long time, and eventually died. I have observed a cancer of the breast to atrophy, break down, and the wound wholly to close. Death took place from an internal metastasis. I lost sight of the patient finally. “Das Krebsgewebe hat eine grosse Neigung zuni Zerfall” (Riegel.).

Frank H. Pritchard, M.D.

OBSERVATIONS ON THE SURGERY OF THE BRAIN, BASED ON FORTY-SEVEN OBSERVATIONS AND EXPERIMENTAL RESEARCH.—George W. Crile, M.D., Cleveland, O., in describing the above, says: “The experiments were performed according to the methods in vogue in physiologic research. Graphic records of the various phenomena were taken on smoked drums, and the statements made may be verified by tracings in my possession.

“1. *Traumatisms, experimental*, such as blows, compound fractures of the skull, bullet-wounds, etc., in almost every instance affected the respiration more than the circulation. Death was produced in one instance by respiratory failure from the effect of a bullet that did not even touch the brain, but passed very close to the medulla. The effect upon the circulation varied greatly—sometimes slowing, sometimes acceleration, sometimes irregular action. The most important first indication in many cases would be for artificial respiration. A case of a gunshot wound in the navy in the Spanish-American war died of respiratory failure, the heart beating for some minutes after respiration ceased.

“*On Increased Intracranial Pressure*.—Symptoms of pressure do not usually appear until the brain has been compressed of 5 per cent. of its volume. (Experiments on dogs.) The pulse is slowed sometimes to more than half its normal rate. Irregularity of rhythm may early develop. If the pressure is continued long, the cardio-inhibitory mechanism becomes exhausted, and there is rapid heart action, alternating with slow. The vaso-motor centre is early affected and readily exhausted. Great irregularity in the rapidity of the heart's beat foreshadows dissolution of the cardiac centres and death. Respiration was in almost every experiment affected in advance of the circulation. The active phase of the expiratory act was first affected, then the inspiratory. The respiratory centre showed itself to be more sensitive than the cardiac, and indicated earlier pathological pressure. When the brain is under pressure, the amount of anæsthetic necessary to produce surgical anæsthesia is proportionately less. Sudden respiratory failure is likely to occur, and an

assistant should be detailed to perform artificial respiration, while the operator opens and cuts away the skull with as much dispatch as is consistent with safety, to relieve the pathological pressure. Natural respiratory action is usually inaugurated as soon as the brain is relieved of its abnormal pressure.

"Clinical observations support the experimental, that operations performed in the presence of sudden alternating rate of heart-action with irregular rhythm are extremely unpromising. This state foreshadows breakdown of the centres and death.

"*On the Compressibility and Elasticity of the Brain.*—Experiments show that the brain substance is practically incompressible, but that it has a considerable elasticity. The elasticity is a property of the brain tissue itself, and is but slightly modified by change in the blood pressure. The elastic recoil, however, is modified by blood pressure. In elevation of depressed fractures, evacuation of blood-clots, abscesses, etc., the elastic recoil is clinically observed.

"*On the Cerebellum.*—On immediate lesion of the cerebellum, remarkable compensations take place. Animals may live after the ablation of the entire cerebellum. The absence of clinical symptoms in the slow development of tumors or abscesses is due to the compensation that takes place *pari passu* with the development of the morbid process. Experiments show that when one lateral lobe of the cerebellum is removed there is a strabismus, such that the opposite eye is directed downward and outward, while the eye on the same side as the lesion is little, if at all, deviated. There are present nystagmus, and motor phenomena, consisting in partial or complete paralysis of the limbs of the same side as the lesion, and an increase in the muscular rigidity of the same side. There is an inco-ordination, with reeling and rotation toward the opposite side from the lesion; there are sensory phenomena, including blunting of sensibility on the same side as the lesion. The reflexes are greatly increased on the side of the lesion. The differences and confusions existing among clinicians and experimenters regarding cerebellar phenomena may be greatly due to the fact that the observers do not adopt the same rule in describing such symptoms as reeling and falling to the right or to the left, as to whether it applies to the observer or to the observed.

"I have been able to verify in three different instances the deviations of the eye while performing operations and while making explorations to search for tumors. In none of these cases were any effects noted upon the eye after the actual irritation caused by exploration had ceased. The cerebellum is a safe field for exploration. Experimental evidence proves that this organ does not act as a whole, but that its halves, if divided mesially, perform their functions equally well. While the cerebellum has a crossed action on the brain, it has a direct action on the spinal cord."—*International Journal of Surgery*, December, 1899.

Woodward D. Carter, M.D.

NOTE ON SPERMATOCELE, WITH CASE.—J. Henry Dowd, M.D., Buffalo, N. Y., reports the following: J. H., aged 47, single; occupation, pipe-line walker, oil-fields, Pennsylvania.

About June 15th, while walking through a ravine, caught his foot in a twig, falling forward and striking, but lightly, against a fallen tree, which touched the body about its centre. At the time he noticed a slight twinge of pain in the right testicle, but nothing that prevented the continuing of his journey. That evening he noticed considerable swelling, but this was pain-

less and gradually disappeared, leaving only a small rounded body, the size of a hickory nut. This swelling persisted, but in no way interfering with his occupation, which consisted in walking about eight or ten miles daily over very rough roads. On July 19th he came into the hospital, not for any physical suffering, but for advice and to allay the mental anxiety that the growth might destroy the gland. After a careful examination of testicle, prostate and vesicles, a diagnosis of spermatocele was given, with the suggestion that it could be removed and in no way interfere with the sexual function or destroy the gland. Consenting to its removal on July 21st, chloroform was administered and the dartos laid open down to the tunica vaginalis. Here it was found that, although the growth lay behind this, it would not be possible to reach it without cutting through the latter. This was done, both layers being divided, and the pedicle—if such I may call it—was ligated and cut away from its connection, with the head of the epididymis (vas afferentia). In doing this the knife accidentally cut through the very thin wall, but the fluid was caught, and, later, examined, and the correctness of the diagnosis proven.

The two layers of the tunica were sewed with fine gut, and the dartos, with an uninterrupted suture, was closed over all. Healing took place by first intention.

Woodward D. Carter, M.D.

A NEW METHOD FOR REDUCTION OF STRANGULATED HERNIA.—H. C. Owen, A.M., M.D., Baldwin, Kansas, describes the technique as follows:

The operation is performed as follows: The field of operation, hands and instruments are rendered aseptic. No anesthetic is needed. A trocar is selected which carries a canula, the lumen of which is about one line. The most dependent portion of the tumor is selected. If scrotal, the operator must see that a testicle is not in the way; then hold the tumor securely with the hand; with the right hand seize the trocar, letting one finger press firmly at a point indicating the depth to which it is wished to pass the instrument; then at one quick thrust drive the instrument through all the tissues and into the lumen of the bowel.

The instrument should always be passed in the direction of the long axis of the bowel. The point of the trocar should be toward the opening through which the tumor passed out from the peritoneal cavity, so that if the bowel should be liberated and passed back into the abdominal cavity it could slip easily off the instrument without danger of tearing. Now, as the trocar is withdrawn the flatus quickly passes through the canula, leaving the tumor quite soft, with, in many cases, only a small amount of fecal matter to be removed. The next step is to attach a reversible pump to the canula and pump in a small quantity of warm sterilized water; then kneed carefully for a few minutes and pump it out. This is to be repeated until all fecal matter is removed from the incarcerated bowel. Leaving the canula remaining, it is next advisable to inject into the emptied bowel the following: Morphine sulphate, gr. $\frac{1}{4}$; water, 2 drams. The canula is now withdrawn and thirty minutes allowed to pass for the morphine to be absorbed, to control peristalsis, and swelling to close wound in bowel sufficiently to prevent leakage into peritoneal cavity after the bowel is returned.

After the proper amount of time has passed the procedure is resumed thus: Elevate the hips, flex the thighs on the abdomen and apply taxis, gently, and the bowel will pass easily back into the abdominal cavity in a large proportion of cases.—*Amer. Jour. Surgery and Gynecology*, Nov., 1899. W. D. C.

THE VALUE OF ANTISTREPTOCOCCIC SERUM IN THE TREATMENT OF PUERPERAL INFECTION.—The report of the committee of the American Gynecological Society gives the results of their studies and observations in the following conclusions :

1. A study of the literature shows that 352 cases of puerperal infection have been treated by many observers, with a mortality of 20.74 per cent.; where streptococci were positively demonstrated the mortality was 33 per cent.

2. Marmorek's claim that his antistreptococcic serum will cure streptococcic puerperal infection does not appear to be substantiated by the results thus far reported.

3. Experimental work has cast grave doubts upon the efficiency of anti-streptococcic serum in clinical work by showing that a serum which is obtained from a given streptococcus may protect an animal from that organism, but may be absolutely inefficient against another streptococcus, and that the number of serums which may be prepared is limited only by the number of varieties of streptococci which may exist.

4. Thus far the only definite result of Marmorek's work is the development of a method by which we can increase the virulence of certain streptococci to an almost inconceivable extent, so that the one hundred billionth of a cubic centimetre of a culture will kill a rabbit.

5. The personal experience of the committee has shown that the mortality of streptococcus endometritis, if not interfered with, is something less than 5 per cent., and that such cases tend to recover if Nature's work is not undone by too energetic local treatment.

6. Curettage and total hysterectomy is unhesitatingly condemned in streptococcus infection after full-term delivery, and a large part of the excessive mortality in the literature is attributed to the former operation.

7. In puerperal infections a portion of the uterine lochia should be removed for bacterial examination, and an intrauterine douche given just afterward of four to five litres of sterile salt solution. If the infection be due to streptococci the uterus should not be touched again, and the patient be given very large doses of strychnia and alcohol, if necessary. If the infection be due to other organisms, repeated douchings, and even curettage, may be advisable.

8. If the infection extends towards the peritoneal cavity, and in gravely septicæmic cases, Pryor's method of isolating the uterus by packing the pelvis with iodoform gauze may be of service.

9. The experience of one of the members of the committee with antistreptococcic serum has shown that it has no deleterious effect on the patient, and, therefore, may be tried if desired. But we find there is nothing in the clinical or experimental literature, or in our own experience, to indicate that its employment will materially improve the general results in the treatment of streptococcus puerperal infection.—*American Journal of Obstetrics*, September, 1899.

George R. Southwick, M.D.

PAROTID-GLAND THERAPY IN OVARIAN DISEASE AND DYSMENORRHOEA.—(Shober).—Mallett reported twenty cases of ovarian disease treated by the parotid-gland extract with remarkable and gratifying results, particularly in dysmenorrhœa. Almost immediate relief from pain followed the treatment,

and enlarged, tender and apparently adherent ovaries, at the end of a few weeks' treatment, became reduced in size and could be palpated without pain.

The class of cases selected by Shöber were cases of ovarian congestion and cases of chronic oöphoritis unassociated with extensive pelvic inflammatory disease; cases where the tubes are not extensively involved, and where there exists very little if any exudate. In these cases the enlarged, tender, prolapsed and sometimes adherent ovaries can be readily outlined, especially when the examination is made under an anæsthetic. These women suffer constant discomfort and severe pain, becoming aggravated a few days before the menstrual period, which is often irregular, and may be free or scanty. There is often some relief from pain with the flow, but more often the dysmenorrhœa is severe. The pain is situated in one or both iliac fossæ, and radiates to the bladder, rectum, sacrum, hip, and down the affected side. The cases reported have all suffered with these painful symptoms for many months or years, and have been unable to obtain relief by other forms of treatment. All of these cases experienced great relief from pain, and the results indicated that parotid-gland feeding relieves ovarian pain and causes reduction in the size and tenderness of enlarged and sensitive ovaries; also that under the influence of this agent the menses become regular and less painful.

George R. Southwick, M.D.

RECTAL IRRIGATION.—(Hyde.)—Irrigation of the rectum with hot water is sometimes preferable to the vaginal method, as it acts more directly on the pelvic circulation. It avoids washing away the protecting acid mucus of the vaginal fornix, and is to be preferred for young girls. It is of special value for chronic pelvic inflammations, with the exception of pyosalpinx. It is particularly valuable for the early stage of intestinal paralysis following sepsis and to relieve tympanites. Dr. Hyde is a firm believer in rectal irrigation in the treatment of hæmorrhoids. If employed early, it will abort them in 99 cases out of 100. It has also proved one of the most valuable of remedies for acute nephritis with the secretion of a small amount of urine.—*The American Gynecological and Obstetrical Journal*, August, 1899.

PARALYSIS IN THE NEW-BORN.—(Schoemaker.)—This condition affects one of the upper extremities, and is due to stretching some portion of the fifth nerve or of the brachial plexus. The following precautions are advised in the management of labor: Use only a moderate amount of traction on the head, without rotating it, in extracting the body of the child in vertex presentations. It is better to use the forceps to extract the aftercoming head than to pull too vigorously on the neck in manual extraction. Twisting or rotating the head beyond an angle of 30° is especially dangerous. Forceps extraction should be judiciously performed, and assisted by expression, especially if the shoulders offer undue resistance at the pelvic brim.—*Zeitschrift für Geburtshülfe und Gynäkologie*, vol. xli., H. 1, 1899.

George R. Southwick, M.D.

SECONDARY CATARACT.—Any opacity remaining in the pupillary area after the removal or absorption of the lens is commonly designated as secondary or after cataract. This secondary opacity may be due to the wrinkling of the remaining capsule; or, by a gradual opacification of the epithelial cells within its folds; or, by the retention of some portions of the opaque lens

during the operation of extraction ; or, of clear lens matter which sooner or later becomes opaque ; or, as the result of inflammatory action within the capsule itself or the contiguous structures, a membranous deposit will occupy the pupillary space. While any one of these causes may be sufficient, yet a large proportion of cases arise from a combination of all.

If the impairment of vision following the extraction of the lens is the result of some portion of the lens being left behind during the extraction, the pupil will very soon be filled with a more or less dense white mass, and will offer a most discouraging outlook to the patient.

Experience shows that a clearing by absorption of this mass will occur, if inflammatory complications are absent.

By a wrinkling of the remaining capsule the pupil is found to be occupied by a surface not unlike that of watered silk, usually not making itself evident for months, sometimes for years, after the extraction. The pupillary space may become filled with a dense membrane of plastic material promptly after the extraction, from the inflammatory action during the progress of an iritis or capsulitis, or both ; or from slowly-progressing irido-choroiditis it may develop many weeks subsequent. While a certain proportion of secondary cataracts may be looked upon as dependent upon processes beyond our control, yet he thinks that by attention to means that will limit the amount of traumatism and inflammatory action, and by securing a clearer pupillary space, a considerable number might be prevented. Contributing toward the prevention of secondary cataracts, he thinks we should include certain points in the operative technique.

(1) One of the first requisites for securing complete removal of the lens from its capsule is that the opacity shall be as nearly as possible complete, that is, that the cataract be ripe.

(2) One of the most important factors in not only securing a pupil free from cortical remains, but probably also in lessening the risk of plastic inflammatory action, lies in the performance of a preparatory iridectomy.

(3) By limiting the traumatism, reduce the risk of formation of inflammatory pupillary deposits, foremost is the placing of a 'generous section of the cornea.

When the corneal incision is limited, to force the delivery through the insufficient opening is at the risk of scraping off the cortex and leaving it in the anterior chamber.

(4) A careless or insufficient capsulotomy will often not only add materially to the traumatism, but will invariably result in the retention of more or less cortex between the capsular layers.

(5) Absolute quiet of the patient and of the eye during the first days of healing must certainly add their influence in securing freedom from inflammatory pupillary deposits.

(6) Finally, after the healing process is completed, it is, he thinks, an important question as to whether we do not often favor the development of pupillary deposits by too early an adjustment of the glasses and the use of the eyes. He is in the habit of continuing the use of the mydriatic for two or three weeks after the patient is discharged, and, when possible, make no correction of the refraction for from four to six weeks after the healing.—Chas. M. Thomas, M.D., Philadelphia, *The Homœopath Eye, Ear and Throat Journal*, October, 1899.

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

NATRUM SULPH. IN TRAUMATIC EPILEPSY.—Blackwood reports a case of epilepsy, the spasms resulting apparently from an injury to the head, and the affliction being of ten years' standing at the time of record. Kali phos. 6x was given for one week, and overcame the complete urinary incontinence that existed. Two weeks later, having had one spasm, he was given natrum sulph. 200x, night and morning, for one week, followed by placebo. Four months have since passed; he has had no return of the spasms, and has perfect control of the urine. Arnica montana has, on several occasions, controlled meningitis due to traumatism, but it has never been of any service to the writer in epileptiform seizures. Here natrum sulph. has permanently cured two cases undoubtedly epileptiform in character and traumatic in origin.—*Clinique*, 1899.

F. Mortimer Lawrence, M.D.

REMEDIES FOR PNEUMONIA.—Humphrey, of Plattsouth, Neb., states that of the great number of remedies advised for pneumonia a few well selected have served the purpose. Veratrum vir. presents such strong indications that one expects it to be indicated often; but such is not the case, and even when indicated it has disappointed him frequently. If veratrum vir. does not produce marked lowering of pulse and temperature within twelve hours it never will, and its continuance only weakens the heart. Given very early after the close of the chill, and while the congestion is very active, veratrum vir. will sometimes arrest the whole trouble promptly; but only twice in his experience of fifteen years has this happened. Aconite 2x, bryonia 2x, phos. 3x, tart. emetic 3x, sulphur 3x and 30x have constituted a working basis in the management of this disease. If he were to say that any of these had been of greater service than others, he would select bryonia first, with phosphorus a close second, often finishing the work begun by the former.—*Clinique*, 1899.

F. Mortimer Lawrence, M.D.

IGNATIA IN PUERPERAL MANIA.—Taylor, of Chicago, has found ignatia a valuable remedy in puerperal mania in hysterical subjects. Unlike stramonium and hyoseyamus, it does not produce marked hallucinations and delirium. Moods are the characteristic symptoms. She is morose, glum, refuses to speak, and secludes herself for hours, followed by laughter, extremely loving deportment, very talkative, and often silly. This condition may continue for a few hours or days, and then, without any apparent provocation, she becomes a raving, obscene, violent maniac. He had one case of long standing in which the three moods were manifested nearly every day,

but were always worse at the menstrual period. The flow is always scant, black and of disagreeable odor, and during that period the patient sleeps little, urinates very freely, and the bowels are inclined to be loose. While the patient may have a large number of symptoms, the above are keynotes calling for ignatia. — *Clinique*, 1899.

F. Mortimer Lawrence, M.D.

PASSIFLORA INCARNATA IN WHOOPING-COUGH.—According to Cartier, of Paris, *passiflora incarnata*, a remedy little used in whooping-cough, serves well for the sleeplessness, spasms and certain nervous phenomena. Frequently when lying down at night the attacks are worse, and hyosey., bellad. and conium will not serve as well as *passiflora*, five drops of the mother tincture at bedtime. Another plan is to give two drops of the tincture immediately after each attack until the total quantity taken in the night is from six to twelve drops. The preparation of the tincture is important—it should be made from the wild plant, and not from the cultivated variety. There is the same difference between the aconite of the mountains and the garden variety. — *Monthly Hom. Review*, 1899.

F. Mortimer Lawrence, M.D.

REMEDIES FOR CHRONIC SEMINAL VESICULITIS.—Wright, of London, recommends "stripping" the vesicles, the use of ichthyol suppositories, and galvanism. In addition, internal treatment is of the greatest importance. Of remedies, he has found most benefit come in the earlier stages from the use of acid oxalic or acid phosph. The former is most used in those cases in which great languor and lassitude are present. There is increased frequency of micturition, with some pain and burning. The testicles are often tender. Considerable sexual excitement. Oxalates or uric acid are present in the urine. Acid phosph. has much the same symptoms, but phosphates in the urine are its main indication. It is especially useful after sexual excess. Acid picricum, so useful in prostatic cases, he has not found of much benefit. When there is much pain, gelsemium is often helpful. Hepar sulph. is sometimes indicated where emissions are frequent. Ammon. brom. is, perhaps, the most suitable remedy where there is much mental distress. Each case will probably need many changes in the remedy before a cure is complete. — *Monthly Hom. Review*, October 2, 1899.

F. Mortimer Lawrence, M.D.

TINNITUS AURIUM.—Dr. Goullon, of Weimar, Germany, in a young and blonde girl of a lymphatic temperament, who suffered from roaring in the ears, after an unsuccessful administration of rhus and merc. solub., obtained a very rapid and a complete cure by silica 12x, which drug he thinks superior to ferrum phos., gels., iod., kali and calc. phos., nitric acid, mezereum, elaps and thuja.

THE HOMŒOPATHIC REMEDIES IN THE DIFFERENT TEMPERAMENTS, DIATHESSES AND DYSCRASIAS.—Dr. Bernard Thomas, in an interesting article on this subject, first mentions the temperaments.

Nux is preferably indicated in thin, slight persons, it acting less pronouncedly in muscular subjects. The patient is irascible and promptly yields to impulses. His complexion is yellowish, though at times there may be red spots on his cheeks. Generally he is very sensitive to intellectual effort. All these peculiarities are aggravated by sedentary habits.

Sepia acts in men, but more particularly in obese and flabby women, and less rarely in thin ones who have a yellowish skin, or one which is yellowish-brown, dirty and flabby, who sweat in their axillæ, perinæum, and on their backs; they suffer from nerves and headache, and awaken in the morning fatigued and aching.

Pulsatilla corresponds to a timid spirit, and a tendency to a calm and quiet sadness, or at least to preoccupation.

Sulphur is usually indicated in persons of a pale complexion who are over-excitable, though it also acts very well in negroes. These patients are very subject to skin diseases of different kinds. The skin often has a peculiar and special odor; the hair is thick and rough.

Aconite is applicable in persons who are plethoric and sedentary, and who are inclined to a pigmented skin.

Agaricus is indicated in those whose skin is flabby, the hair light-colored, and in old persons with an indolent circulation.

Alumina in thin and emaciated patients, as well as in old persons.

Graphites in persons with a tendency to obesity, especially in women subject to delayed menstruation and constipation.

Secale, contrary to *sepia*, is indicated in thin and scrawny women with relaxed muscular fibre, who are weak and cachectic, and in worn-out and decrepit old persons.

As to the diathesis, in the scrofulous, in the sanguine or serous variety he finds the principal remedy to be iodium, sometimes aurum, puls., calcarea, and possibly agaricus.

The lymphatic or melancholic variety, of which the typical remedy is sulphur, and sometimes merc., hepar and silica.

Gout is a hereditary diathesis; and though the hygienic measures are of capital importance, the remedies should not be neglected.

Nux stands at the head, and then *lycopodium*. The hæmorrhagic diathesis is rare, and has a certain relationship with the gout. *Phosphorus* is the chief remedy. The rheumatic diathesis is best treated with *actea*.

A catarrhal diathesis is sometimes mentioned where the patient is very sensitive to changes of temperature. *Pulsatilla* appears to be the remedy here, but at the moment of the acute crises the remedies are *acon.*, *bry.*, *ars.*, *dule.* and *senega*.

Among the dyscrasias may be noted rickets. The remedies containing phosphorus are the principal ones—*phos.*, *phos. acid.*, *calc. phos.*

The scurvy requires remedies containing chlorine, as *natrum mur.*, *ammonium mur.*, and sometimes muriatic acid.

Osteoarthritis will often be relieved by *colchicum*, *ars.* and *rhus*.

The cancerous cachexia most frequently requires *arsenic*.

In short, the physician should not only keep an eye on all the symptoms of a disease, but also consider the soil upon which the disease develops. A constitutional remedy administered from time to time often completes the cure or renders it more rapid.—*Journal Belge d'Homœopathie*, No. 6, vol. v.

Frank H. Pritchard, M.D.

A FEW REMEDIES IN PULMONARY TUBERCULOSIS.—Dr. Arnold, in a paper recently read before the British Homœopathic Society on the Modern Therapeutics of Pulmonary Phthisis, said that he regarded climatic treatment of the greatest importance. Finally, he mentions as the three chief reme-

dies sanguinaria, which in early stages may be decidedly curative; jaborandi, which in night-sweats has never failed him, and arsen. iodatum.—*Zeitschrift des Berliner Vereines Homoeopathischer Aerzte*, 1899, Hft. iv. In the same journal there is a note stating that Dr. Marc Jousset has succeeded in obtaining a cure in one case of the same disease with ars. iod. 6x and calc. phos. 6x, given on alternate days. In the November number of the *HAHNEMANNIAN MONTHLY* of 1899 is an abstract of a good article on the dispensary treatment of phthisis, in which the iodide of arsenic is favorably mentioned. Agaricin 1x, given five to six hours before the hour of sweating, has acted well in the night-sweats for me. Iodoform is also a useful drug in pulmonary tuberculosis. In early cases I have at times obtained good results with the tincture or fluid extract of eriodictyon glutinosum (yerba santa).

Frank H. Pritchard, M.D.

APOCYNUM CANNABINUM.—Dr. Turner recommends apocynum cannabinum in general dropsy of cardiac origin. The dose should be almost sufficient to produce vomiting.—*Zeitschrift des Berliner Vereines Homoeopathischer Aerzte*, Hft. iv., 1899. In 1894 Professor G. Petteruti, of Naples, published in the *Policlinico* a study of the action of this drug on the heart muscle and as a diuretic. Employing a decoction of from two to three gms. of the dried root in one hundred and fifty gms. of water, two to three times a day, he found that it acted both as an emetic and a cathartic, even after one day, and thus prevented it being employed in heart cases as one would expect, for this dose would certainly be far too great. As to the tincture, he has obtained better results with it, though he regards the doses advised by Murray, five to ten drops three or four times a day, as much too small, and with them he has gotten little or no results, and not until he increased to sixty or even ninety drops a day did he obtain satisfactory therapeutic results. He did not exceed this, for if he did, arrhythmia would be produced, which would prevent its further use. He asserts that with the tincture he has not been disturbed by the emeto-cathartic action associated with the use of the infusion, and he thinks that there are two principles in the drug, one to which is due the emeto-cathartic action, soluble in water but not in alcohol, and the other, the cardio-kinetic, or heart- tonic and diuretic principle, which possesses the contrary properties, and is not soluble in water but in alcohol. One of the most pronounced actions is an increase of the quantity of urine, which was very notable in some cases. This drug is not an irritant to the kidneys, as cantharides and squills. In all cases the quantity of albumin has not been increased by its use, but rather, on the contrary, did it tend to disappear. In other cases, where there was no albuminuria even after forty days' use of the remedy, in the maximum dose there was no albumin noted. Finally, the diuretic action resembles that of digitalis, adonis, strophanthus, sparteine, etc. Another frequent and almost constant result of his experiments was increase of the strength of the heart-beat as noted by the pulse and the sphygmograph (Dudgeon's). Another pronounced result has been a reduction of the number of the heart-beats; if the treatment be prolonged, or the dose increased, irregularity would follow: an intermittent pulse. In the majority of cases the arterial pressure was raised, and in one case the quantity of urea excreted was augmented. In a case of aortic insufficiency no results were obtained. As a result of this action the phenomena of cardiac insufficiency

rapidly disappeared, the œdema either wholly vanished or was greatly ameliorated, and consequently the dyspnœa was influenced in the same manner. He thinks that similar results would not have been obtained from rest, as most of the patients had been for some time under observation at the hospital, some of them for months. In some, after they had been greatly relieved by the drug, on suspending the drug for fifteen to twenty days their old troubles would reappear. In short, it follows from this that apocynum is not only a diuretic, as has long been known, but is also an actual heart-tonic, as digitalis, for example. I have found it particularly valuable in cases of heart insufficiency, accompanied by or depending on old and chronic renal inflammations or degenerations in old persons. Here it will rouse the kidneys and heart to activity, and give them weeks and months for further usefulness.

Frank H. Pritchard, M.D.

CACTUS GRANDIFLORUS.—Dr. Byres Moir, of London, places cactus, in its action, between aconite and digitalis. It acts well in inflammatory states of the endocardium and strengthens the contractions of the heart-muscle. It has produced in its provings pericarditis, as well as inflammations of the myocardium itself. Moir recommends it in rheumatic inflammatory processes in doses of two to five drops of the tincture (probably as a prophylactic of endocarditis), according to the age of the patient.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Hft. iv., 1899. Cactus grandiflorus, in my opinion, is a much overestimated remedy. I have taken eight ounces of the tincture during the course of an afternoon without any appreciable results beyond a little exhilaration from the alcohol, and I must say that that was not very pronounced. I was able to walk to my boarding-house, over a mile distant, without any difficulty. Any one who has read Rubini's original monograph will see that he must have been gifted with a wonderful imagination.

CARBOLIC ACID IN ECZEMA.—Dr. Mossa asserts that this remedy is frequently employed and is recognized as wholly homœopathic to eczema, acute or chronic, dry or humid, and especially of the extremities. The writer has cured with it two cases of eczema of the mucous membrane of the lips and eyebrows.—*Journal Belge d'Homœopathie*, No. 4, 1899.

Frank H. Pritchard, M.D.

CHININUM SULPHURICUM IN PERIODIC HEADACHE.—Dr. Berlin was consulted by a woman of forty years, who, somewhat pale, complained of weariness at times. Her appetite was moderately good. Of nights she sweat a great deal; now and then roaring in the ears. Her chief complaint is a headache, which she had had for weeks. It is indefinite, now boring, now pressing, then throbbing. It seemed to occupy the whole head, though it was greatest in the forehead. During the headache she felt cold through her whole body. The whole scalp was sensitive and all contact would either produce or aggravate the headache. Lying quietly ameliorated. The pain would appear every forenoon at ten o'clock and last until five o'clock in the afternoon, when it would gradually cease. On account of the periodical appearance he gave her chinin. sulph. 3x, five drops every two or three hours. It only recurred once again, and then very slightly.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 19 and 20, 1899.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

FEBRUARY, 1900.

"DIFFUSE SEPTIC PERITONITIS TREATED BY CONTINUOUS IRRIGATION."

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Philadelphia Medical Club, Jan. 3, 1900.)

THE following case presents sufficient points of interest to warrant its being recorded, the method of treatment having been suggested but a short time since (Laplace, *Philadelphia Medical Journal*, Oct. 14, 1899).

J. W. W. L., male, 24 years old, had been carried through several attacks of undoubted appendicitis, after each of which his medical attendant, Dr. T. H. Carmichael, had advised an interval operation. With the same end in view, the doctor had undertaken the seizure in question, but the symptoms becoming unfavorable, he asked me to see the case with him on the afternoon of November 19th. The attack was twenty-two hours old and had been a moderate one, no more severe than previous ones, until the doctor's visit shortly before the consultation. The pulse was rising and had reached 120; respirations were quickened (28) and superficial; the distention was rapidly increasing, the bowels having been "on the move" previously, as regards gas and stools. To this was added a multiplying belching and an intermittence of the localized pain. The tenderness, however, was exquisite, and extended downward and inward, with the usual associated muscular rigidity, which lacked the characteristic "rod-like rectus feel" because of the downward and inward direction of the former.

At Dr. Carmichael's request the patient was, for obvious reasons, at once transferred to a private room at the Hahnemann Hospital; and, as the sequel will show, his insistence was well rewarded. As soon after admittance as the local preparations permitted, operation was undertaken under ether anaesthesia, the patient's condition being such as to cause the greatest anxiety on the part of the administrator, Dr. G. A. Van Lennep, who advised the minimum time-limit possible, and who was obliged, during and after the operation, to resort to the customary cardiac stimulants, infusion being omitted on account of the shortened operative procedure, which will be described later on.

The abdomen was opened by the vertical (Langenbuch's) incision, which was freely extended to the groin. The appendix was found intensely congested, covered with a fibrino-purulent exudate, and hanging downward and inward over the brim of the pelvis. There was a feeble attempt at isolation by protective adhesions, but neither perforation, gangrene nor concretion were present, Prof. Hall's report of the specimen being as follows: "The entire appendix is swollen, its lumen being distended and filled with pus from end to end. The mucous layer is destroyed; about three-eighths of an inch from the distal extremity the muscular coats are infiltrated with round inflammatory cells, and over a small area this is so severe as to destroy the muscular fibres. Thus a suppurative area extends almost to the peritoneal coat, perforation being nearly completed. Diagnosis, acute suppurative endo- and parietal appendicitis."

The pelvis and the abdomen generally contained a quantity of thin, offensive, sero-purulent fluid which must have run up into the pints, if not the quarts. The appendix was tied off and its stump cauterized with carbolic acid, its mesentery, which bled freely, being ligatured and rubbed with aristol.

As the patient's condition would not permit of evisceration and extensive irrigation, an attempt at which induced collapse, I was led to follow Laplace's suggestion of continuous, post-operative irrigation. This was accomplished by inserting an ovariectomy glass tube inverted, the perforated end being covered by rubber drainage tubing, through the lower angle of the wound into the bottom of the pelvis. Another bent glass tube "right end up" was placed under the liver and connected with

a rubber tube which would lead into a tub beside the bed. The intermediate peritoneal layers were closely sutured and the closure tested by liberal irrigation before the patient was removed from the operating table. The balance of the wound was left open.

Continuous irrigation was kept up for about twelve hours, nearly twenty gallons of sterilized normal salt solution being passed into and out of the peritoneal cavity during this time. Purgation and energetic enemata were at once undertaken. It was then deemed advisable to intermit the irrigation on account of the dyspnoea and rapid respiration (from 40 to 50), which immediately dropped into the thirties, and particularly on account of the pain and distention, which had become unbearable.

It was my intention to renew the irrigation, which was successfully kept up in Laplace's case for seventy-two hours, but the tubes would not work, distention and its concomitants being alone induced; they were therefore removed. Before this the pulse had dropped to 80, and purgation from above and below produced moderate results; by the third day peristalsis was well established, and while requiring assistance, the bowels responded readily.

The case then resolved itself into one of acute septicæmia, the temperature gradually rising with the characteristic zigzag until it reached its highest point (103°) on the fourth day, and coming down to sub-normal as the danger-line was passed (eighth day); the pulse increasing again up to 150, after which it became imperceptible during the greater part of the fifth day, when the patient was several times thought to be dying; the respirations multiplying until they amounted to from 30-odd to 40-odd. The other symptoms were classical: progressive prostration until the patient's extremities became cold and he was bathed in a clammy sweat; diarrhœa, with frequent colliquative stools, finally becoming involuntary; scanty urine, passed in like manner at times; mental hebetude, then delirium, stupor, and almost coma; petechiæ, moderate icterus, and a peculiar offensive smell of the body surface.

On the afternoon of the 20th ten c.c. of Pasteur's antistreptococcus serum were injected by Dr. Lackie, the house surgeon, to whom are due my thanks for devoted care of the case. This

was repeated on the 21st, 22d and 23d, and two were given on the 24th, the worst day. Fearing a possible toxic effect, although each injection was followed by a prompt and evident improvement, they were stopped until the thirty-third day, during which time the symptoms were those of a moderate or chronic septicæmia, the temperature and pulse keeping persistently near or above 100, while the patient presented signs of circulatory and general depression. Although a reactionary tendency to constipation gave rise to aggravations apparently dependent upon auto-intoxication, which were relieved by thorough evacuation, the general, persistent, what might be termed sneaking totality did not clear up until the above-mentioned antistreptococcic injection, since which time all has been plain sailing. This produced a distinct but temporary temperature and pulse reaction, offset by an unmistakable and continuous improvement. The general treatment consisted of nourishing, easily assimilated diet; the continuous use of alcohol by the mouth or under the skin; heart stimulation by Strychnia principally, and now and then by Digitalin, Glonoin, etc.; and the internal administration of Arsenic, with an occasional intercurrent remedy according to indications—in short, the routine treatment of an acute, followed by a chronic septicæmia.

Twenty-four days after the operation, Dr. J. W. Hassler, who kindly took my cousin's place during his absence, made a secondary suture of the granulating wound, pushing back the protruding colon, and successfully uniting the divided muscles and fascia. Mention of his untiring attention should be added to that of the gentlemen already named. The patient is now ready for his truss and his discharge.

This case is instructive in two lines: the serum therapy and the continuous irrigation. My personal experience is probably that of every abdominal operator who meets with a considerable number of peri-appendiceal lesions. Thus, there are cases of non-limited septic peritonitis in which moderate evisceration, *i.e.*, until we find glistening coils of intestine, with diligent mopping and an abundant gauze pack, arrest the peritonitis and forestall the systemic infection. Most of these I have found to recover. Again, there are cases of universal septic peritonitis in which complete evisceration, generous douching, which would

only spread the non-generalized peritonitis in the above class, and the McCosh intestinal injection of salts, or the introduction of the same through a stomach tube, or energetic subsequent purgation will arrest the process, and the patients recover because a septicæmia has not developed. Most of them, however, will either swell up and die of an unarrested peritonitis or be carried off by an acute septicæmia, in spite, in either instance, of the antistreptococcus serum. I have reported one case in which the infection was so rapid as to amount to a septic intoxication.

I recall, in this connection, two very pleasant exceptions: the one a universal suppurative peritonitis, probably faintly fibrinous and therefore slower in systemic infection, which made a brilliant recovery after evisceration and flooding; the other, a diffuse peritonitis identical with the subject of this paper, in which complete evisceration, deluging irrigation and intra-intestinal purgative injection only partially arrested the bloating and paresis, peristalsis being re-established and the septicæmia subsiding after the administration of 20 c.c. of the antistreptococcus serum, when the lad was almost moribund.

To still another class belong those in which we dare not apply the heroic measures indispensable to the eradication of this horribly lethal process, peritoneal sepsis, when the intelligent anæsthetist bids us beware of hastening the inevitable death. In these cases the method of continuous post-operative irrigation appears to hold out a ray of hope, at least so far as two successful results may encourage us. In the one reported to-night the lines are drawn very distinctly between peritoneal and systemic infection, the irrigation controlling the former, the serum, in my opinion, the latter. We were all impressed, however, with the disadvantages of this method of irrigation, which depressed the heart, calling for energetic stimulants; accelerated respiration, in all probability, although fat embolism may enter as a factor here; and produced distention and pain which called for the exhibition of Morphia, so much dreaded after abdominal operations.

If I might venture an operative conclusion from my experience with these cases, I should say that for the present my plan of treatment would be:

1. In peritoneal infections found to be non-universal: partial evisceration, thorough mopping and generous gauze packing;

followed by antistreptococcus serum injections if recovery is not promptly promised; purgation by any of the methods mentioned being at once energetically instituted.

2. In peritoneal infections found to be universal, with the acquiescence of the skilled anæsthetist: complete evisceration, salt solution flooding, energetic purgation, preferably intra-intestinal, and serum treatment in the presence of systemic symptoms calling for it, practically, in every case.

3. In the same class of cases, when the patient's condition forbids extensive manipulation: Laplace's plan, supplemented by heart stimulants, anodynes and serum therapy.

THE URINE OF CHILDREN—WITH CASES OF DIABETES AND NEPHRITIS FROM PRACTICE.

BY CLIFFORD MITCHELL, M.D. CHICAGO, ILL.

THE writer, having examined the 24 hours' urine of a female child 2 years of age, weighing 30 pounds, in perfect health, obtained the following results:

Volume of urine per 24 hours,	30 fl. ozs.
Specific gravity,	1013
Urea, total,	270 grains.
Phosphoric acid, total,	16 grains.
Uric acid, total,	6 grains.
Ratio of urea to phosphoric acid,	16 to 1.
“ “ uric acid,	45 to 1.

From this it will be seen that in spite of the dogmatic assertion that children pass $4\frac{1}{2}$ grains urea per pound when weighing 40 to 80 pounds, one weighing only 30 pounds passed 9 grains of urea per pound.

The writer, having examined the urine of numerous children, has become skeptical in regard to the relation of urea and uric acid to either age or weight. Not long after examining the urine of the child mentioned above, the urine of a man of 35 years, weighing 140 pounds, was analyzed, and found to contain in 24 hours only 280 grains of urea and $6\frac{3}{4}$ grains of uric acid, or practically about the same as that of the 2-year-old child.

Any one who makes a sufficient number of determinations of urea and uric acid cannot fail to observe that in this region adults pass less and children more than the older books would think normal. Female children from 5 to 15 years void from 130 to 300 grains of urea, in the writer's opinion according to diet and digestion. Boys 10 or 12 years of age void a little more than this on an average.

Diabetes in children increases the excretion of urea; from 400 to 700 grains were passed by two diabetic children of 12, whom the writer saw. Epilepsy tends to increase urea; 4 epileptic children from 8 to 12 years of age voided from 200 to 400 grains.

It will be noticed in the first analysis, that of the healthy girl of 2, that the ratio of urea to phosphoric acid was high, 16 to 1, instead of the usual normal 10 to 1 or 12 to 1; or, in other words, the amount of phosphoric acid was relatively much less than that of urea or uric acid. The writer has noticed that boys of 10 years or less may not void more than 10 or 12 grains of phosphoric acid, and that children in general pass much less of this substance than adults. For example, the same adult whose urea and uric acid was about the same as that of the child of 2 voided 26 grains of phosphoric acid, while the child voided only 16. The average amount of phosphoric acid for adults is said by the older authorities to be 45 grains; but the writer, who has made over 3000 determinations of phosphoric acid in the 24 hours' urine, thinks this figure much too high. For a healthy adult, weighing 145 pounds, the writer regards 35 grains of phosphoric acid as full normal. Class after class of students at the Chicago Homœopathic Medical College, whose urine has been systematically examined, has fallen below this average rather than gone above it. In the writer's experience, children seldom void over 20 grains unless they are epileptics or diabetics, in which cases as high as 40 grains may be voided.

In contrasting, then, the urine of a healthy child with that of an adult of 145 pounds, the writer lays more stress on the elimination of phosphoric acid than of urea or uric acid. In other words, in children the ratio of urea to phosphoric acid must be watched, and a low ratio, below 10 to 1, should certainly be regarded as relatively a sign of waste of phosphoric

acid. It will be interesting to observe the action of remedies on this ratio. We all know how much good calcarea phos. does certain children, and we should determine whether this action is most marked in cases of a high or a low ratio. The writer suggests that internes in charge of institutions where children are kept should study the action of homœopathic remedies with reference to this ratio; it is the most tangible thing we have at our command, and about the only one the writer knows of in which the urine of children differs in marked degree from that of adults from the standpoint of quantitative analysis of normal constituents.

Passing on to the consideration of abnormal constituents, the writer believes that plain traces of albumin are relatively more common in the urine of children than in that of adults. So-called "delicate" children are not uncommonly subject to slight but persistent albuminuria. The writer has not seen, as yet, any nephritic results from such cases. The quantity is usually less than 1 per cent. bulk by the ferrocyanic method and centrifugal sedimentation. Casts are sometimes present, but only a few small hyaline ones, without epithelia or granular *débris* on them.

Sugar is rare in the urine of children, and, when present, invariably (in the writer's experience) means diabetes mellitus. Also there is invariably present the red reaction in the urine with ferric chlorid solution. Add to an inch of urine in a test-tube 3 drops of a 20 per cent. ferric chlorid solution, and if the bottom part of the urine is red (instead of the normal yellow), diacetic acid is present. Every child and every person under 25 with diabetes, whom the writer has examined, has shown this red reaction with ferric chlorid, in this respect differing notably from diabetic adults, in whose cases the red reaction is rare in the absence of drugs from the urine. Certain drugs, as salicylates, give the same reaction and must be excluded.

The coincidence between fatality and this red reaction is shown by the writer in an article which has already appeared in the *HAHNEMANNIAN*.

The writer has seen a number of cases of children with diabetes mellitus; the urine then contains as much phosphoric acid as that of a well-nourished adult. Sugar in the urine of

children is not notably affected by diabetic diet. A certain amount of benefit may be derived in the start from diabetic diet, which must, however, include green vegetables to be beneficial. The writer has at present under his care a boy of 18 who had been passing 160 fluidounces of urine of specific gravity as high as 1040. Under arsenicum and diabetic diet, which included green vegetables, the urine is now about 75 to 80 fluidounces, and of specific gravity around 1030. In six weeks he has gained 3 or 4 pounds, and is considerably stronger. The red reaction, however, is still found with ferric chlorid, and the writer's prognosis is unfavorable. In an adult it is no uncommon thing to see sugar diminish from 7 to less than 1 per cent. in from one to three weeks under proper treatment; but in these cases the red reaction is absent.

Lastly, with reference to sediments in the urine of children, the writer sees more urates and uric acid than anything else. The presence of uric acid in the sediment is not always a sign of excess of uric acid in solution, but a sediment of urates frequently is. This the writer has verified by careful quantitative analysis. Digestive disturbances, the writer thinks, are often at the bottom of these sediments. Nux and calcarea carb. are frequently all that are necessary. When uric acid is deposited, we generally have a hyper-acid condition of the urine, which, in the absence of an indican reaction, may be remedied by lithium carb. But if there is much indican present, mercurius or bryonia may be needed in addition.

During the scarlet fever epidemic of last winter a number of cases of acute post-scarlatinal nephritis were seen by the writer. All recovered except one. It was noteworthy that in the case terminating fatally the tube-casts, at the time when the writer was called in consultation, were mostly fatty, granular and waxy, especially waxy. The writer does not recall ever having seen waxy casts larger or more numerous in the urine, but, nevertheless, ætiology of previous lardaceous disease was wanting. Intra-venous injection of normal salt-solution was faithfully tried in this case, but without effect. Convulsions were a persistent feature, and finally caused death.

The cases which recovered were in some instances critically ill, with urine down to a few ounces per 24 hours, but without convulsions, and without waxy or numerous dark granular casts in the urine.

GENITAL AUTO-INFECTION.

BY THEODORE J. GRÄMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Philadelphia, Sept., 1899.)

IN 1847 Semmelweis began his brilliant and masterly pioneer work, which culminated in his rescuing from hopeless chaos the true explanation of the ætiology of puerperal fever. It is his peculiar merit to have solved this problem, which had baffled the skill and penetration of earnest men for centuries. Many facts had until that time been collected, and many observations had been made which apparently but served to entangle the vexing question in exasperating confusion. It is certainly instructive to study the state of medical opinion just prior to the time of Semmelweis concerning the cause of puerperal infection, and the story of his elucidation of this vital subject must ever have a fascinating interest for every sober-minded student of medicine.

But since the labors of Semmelweis have thus clearly placed the ætiology of puerperal infection on that elevated plane of truth which the searching light of bacteriology has but illuminated, the fact becomes at times evident that puerperal infection has not yet been eradicated from the dangers which surround women when they perform the highest function of their physical life, that of reproduction. As an immediate and direct result of his discoveries, the mortality from puerperal infection was at once reduced from at least 11 per cent. to 1.27 per cent., and since then this diminished mortality rate has been further decreased, so that at the present time a maternity would not be considered as above suspicion which could only show a percentage of mortality of anything over 0.25 per cent.

It is a matter of observation that at times women sicken and die from infection, and the cause is not immediately apparent. Besides these fatal cases of infection there are a number of cases of disturbed puerperium which, while not fatal, are yet attended by a varying amount of danger. Physicians have, therefore, attempted to obtain a satisfactory solution for this fact, and a number have entered the lists in defence of auto-infection.

It is a most important matter for every one to have as clear a comprehension of this doctrine of auto-infection relating to obstetric practice as it is possible from the nature of the subject to obtain; it is also a matter of moment to have rest upon some reliable foundation whatever views may be entertained. Occasionally it becomes apparent in certain quarters that this is not the case, and the thought of auto-infection passes glibly from the lips without an adequate conception, apparently, of the tremendous mass of available evidence which is in contradiction to that idea. No to be correctly informed in regard to this important subject is capable of working an unknown amount of harm directly commensurate with the amount of influence possessed by those who speak of the subject at all. If the idea of auto-infection in anything like a material number of instances be permitted to prevail, the tendency will be distinctly retrograde, and the occasion will be but required to furnish the old-time experiences of so-called "epidemics of puerperal infection." In addition to the bad effect upon the future practice of medical students and nurses from uncertain information received during the time of their novitiate, there remains the evil effect which this idea will exert upon the course of an investigation to find the actual origin of an infection in a given case. This is in many instances an exceedingly difficult task to perform, and then it would be so easy and so quieting to the disturbed conscience to say "auto-infection;" but obstetric science would not be thereby advanced, and obstetric practice would be distinctly injured. While theoretically we may possibly acknowledge auto-infection, even though it occur so rarely as to reach the vanishing point, as it does, it must be denied in practice; therefore it will be better to err in saying that it never takes place than in any instance to foster a recourse for refuge in an idea which is highly problematic, and as yet unproven. I am induced to take up this question in order to supplement, and possibly to complete, my former efforts on this general topic, both before this Society and elsewhere.*

Definition.—Semmelweis said: "The decomposed animal or-

* "The Present Status of Puerperal Infection," *Trans. Hom. Med. Soc. Penna.*, 1896; "Biographical Sketch of Semmelweis," *ibid.*, 1897; "How May the General Practitioner Conform to the Rules of Aseptic Midwifery?" *HAHNEMANNIAN MONTHLY*, xxxii., No. 8.

ganic matter which, being resorbed, induces puerperal fever, is in rare cases not introduced from without, but originates within the boundaries of the affected individual, thereby that organic matters which should be discharged during the puerperium undergo a decomposition before their discharge, and then, if absorbed, induce puerperal fever from self-infection."

Ahlfeld has become the main exponent of auto-infection, and at first charged the cavity of the uterus with being the breeding-place of the poisonous material. More recently he ascribes the cause to the micro-organisms of the air aspirated into the uterus, which effect a decomposition of the decidua, blood clots, lochia, fragments of membranes, or placental remains; from resorption fever follows; from moistening of the wounds with decomposed lochia there results a secondary infection in the vagina and in the introitus. In more recent times Ahlfeld has indicated the manner in which micro-organisms obtain access to the genital canal to be by means of cohabitation shortly before labor, defecation, and various manipulations which pregnant women make on their own genitalia. He has spoken of the micro-organisms adhering to the pubic hair, and to those upon an underlying sheet, but has been criticised for so doing.

The modern form of the teaching of Semmelweis, according to Fritsch, is that "childbed fever is caused by an inoculation of infectious matter or cocci, which, having entered a puerperal wound, causes putrefaction of the wound secretion, the formation of ptomains, and resorption fever."

Kaltenbach (*Centralblatt für Gynecologie*, 1889, 465) says that "only after the demonstration that the genital secretion of healthy women contains fission fungi was the correct grounds for understanding self-infection obtained. The scientific justification of the entire doctrine of self-infection stands or falls with the demonstration whether pathogenic germs are found in the genital organs of healthy women or not."

Doederlein speaks of auto-infection as the process by which fission fungi, already present before labor in the general secretion, attain to development.

Fehling (*Centralblatt für Gynecologie*, 1889, 465) urgently advises that the word "self-infection" be dropped, and rather to speak of direct or indirect infection, or of exogenic or endogenic infection.

Jewett (*Amer. Jr. Gyn. and Obs.*, Apr., 1896, 417) has defined it as "infection from bacterial organisms primarily present in the genital tract," and "as contra-distinguished from contact infection in which the causative agent is conveyed to the patient in the lying-in period." He says "the conception is unfortunate, since all infection is primarily from without. Ovarian abscess, pus-tubes, suppuration of the vulvo-vaginal glands, and other pus-producing diseases pre-existing in the pelvis, may be the source of puerperal fever; but the patient in such cases is already an infected patient, and the puerperal disorder is but the extension of the local septic process. . . . With the exception of vaginitis, the occurrence of parturition and pelvic suppuration is rare. Even the disease-producing bacteria of the vagina are exotics. The term 'auto-infection,' therefore, if used at all, has no proper application in its etymological sense."

The subject of auto-infection is one not to be disposed of in a word. For that reason many painstaking investigations have been instituted with the intention of obtaining reliable information upon the question. From the nature of the subject it has become possible only recently to assume what appears to be an unassailable position in regard to the debated points.

The literature of this subject has lately attained vast proportions, so that it will not be possible, in the limited time at my disposal, to make anything approaching a satisfactory review of it. The solution of the question has been attempted from two different standpoints, namely, that of clinical observation and that of exact bacteriological research. The labors which have been performed in the interest of this subject are highly creditable to all who have engaged in them, for by both methods there has been required a diligent application which must command the respect of all who can in any measure appreciate them.

From a clinical standpoint many almost exhaustive works are at our disposal. I select for hasty review one which happens to be at hand. It is by Dr. Dionys von Szabo, from the Obstetric and Gynæcological Clinic of the University of Budapest, in charge of Prof. v. Kezmarszky (*Arch. f. Gyn.*, Bd. 36, h. 1, 77). It was at this clinic that Semmelweis labored after his return to the home of his childhood; and in this article Kezmarszky is found superintending this investigation which is to further perfect the labors of his illustrious predecessor in the chair.

Von Szabo has made use of clinical material amounting to 8716 cases of labor. These have been recorded with accuracy, so that much information obtainable from these records has a special value on account of being based upon so large a series. With reference to auto-infection, he says we may see what is taught by statistics, by the observation of childbeds with elevated temperatures, and from labors occurring without examination.

Statistics.—From these the following facts appear: The constant diminution of sickness since the introduction of antiseptics; the variation of the illness according to the persons making the examinations; the variations during the course of the same year; the occurrence of sickness in the puerperium in groups; the variations according to the number of births in twenty-four hours; the smallest number of cases of sickness that have occurred since the use of corrosive sublimate.

In regard to the first proposition that puerperal illness constantly diminished since the introduction of antiseptics, a table is furnished of 8716 cases of labor occurring from 1874 to 1887. These years are divided into three periods. During the first period the cases were treated in the old hospital under somewhat unfavorable hygienic surroundings: 55 per cent. were afebrile; the mortality from sepsis was 1.24 per cent. In the second period, with improved antiseptics and better hygienic conditions in the new hospital, 71 per cent. were afebrile, and the deaths from sepsis amounted to 1.60 per cent. In the third period sublimate was used and the antiseptic rules were rigidly enforced, with the result that 80 per cent. were afebrile, the mortality being 0.27 per cent. Von Szabo, therefore, points out that since there has been an improvement of 25 per cent. in the febrile cases in consequence of the more rigid application of antiseptics, the main source of infection must have come from without.

A further source of infection is indicated to exist in cases of protracted labor, where attempts at delivery, or at least examinations, have been made before the patients have come into the clinic. Here again, as Fehling has pointed out, the great variation in the number of febrile puerpera cannot be explained by auto-infection, since in some clinics there are 40 per cent., and in others only 1 per cent. or 2 per cent., where pathogenic germs

are found in the genital tract. Again, the variations in different years, amounting to 25 or 30 per cent., is altogether too large when we consider that the patients come from the same social strata. There is nothing which establishes the assumption that the great variations in the illnesses were in former years due to infection from without, while the 16 or 17 per cent. of the later years were due to the germs in the birth-canal.

There is a variation of puerperal illness according to the persons making the examinations, and von Szabo recalls the observation which caused Semmelweis such anxious thought, that in the clinics devoted to the instruction of medical students there was always a greater percentage of mortality than in that where midwives were taught. The same observation is made from statistics given by Ahlfeld, and again verified from those collected by von Szabo. These cases also reveal the interesting fact that while the number of cases having a single rise of temperature are more frequent in those treated by student midwives, yet the number of cases which have repeated elevations of temperature and the number of cases of sepsis are greater in those patients who were examined and treated by medical students. He reasons that while it is comprehensible why medical students cause illness in women twice as often as do midwives in training, due to engagements in gynæcological clinics and other institutions, yet it cannot be accepted that cases of auto-infection take place twice as often when students examine as when women are in charge. It is also pointed out that there are midwives and certain physicians who, curiously enough, have frequent opportunities of seeing cases of auto-infection, while others have almost none but patients with normal puerperium.

As illustrating the fluctuations of illness during the same year, Table VI. exhibits the influence of students in raising the febrile percentage, and also the difference while the clinic is comparatively clean, after the disinfection, during the vacation, and at the end of the term, when many cases have been treated. The percentages here vary from 6 per cent. to 15 per cent. at different times.

The observations repeatedly made many years ago are again substantiated in that severe illness in the puerperium occurs in groups, and may often be traced to certain offending persons; even slight disturbances are excited in succession, and in those

delivered on the same day. Fifty-four per cent. of the cases sickened in groups, and this high percentage leads to the belief that the same evil influences were active. It would not be correct to ascribe these to auto-infection, and it is very improbable that patients coming from widely-separated portions of the city foster pathogenic germs; it is too hypothetical that the vagina of each of these contain germs of attenuated virulence which in groups would have their virulence restored by identical conditions of the clinic.

In Table VII. are collected the cases delivered in twenty-four hours. It shows that when but one patient is delivered during this time, the results are very satisfactory, and form an exception in the series. The number of normal cases diminishes when more than six are delivered in twenty-four hours, probably because the care in disinfection is less, those engaged being so hurried.

Favorable results have especially attended the introduction of bichlorid as the antiseptic, and the number of sick puerperæ greatly diminished. This being true, it can only depend upon the prevention of infection from without. The germs of the vagina have not been destroyed for their cases are not douched, but it has been sought to prevent their introduction from without, or possibly to prevent the infection by germs adhering to the external genitalia.

In studying the puerperal periods with elevated temperature, it becomes apparent that these have occurred in this clinic when there were wounds of the external genitalia, retention of ovular remains, and during the first day after delivery.

The most frequent cause of elevated temperature resides in the wounds of the external genitalia; through infection these bring about ulcers, transmission of the inflammation in the neighborhood, in the connective tissue, in the glands, and in the endometrium. The frequent illness of primiparæ is generally attributed to the more frequent and more severe lacerations of the birth-canal. Table IX. is formulated with reference to this question, and shows that there is an improvement of 15 per cent. in those who have sustained no laceration. It becomes evident that the nearer to the surface the genital tract is injured, the more frequent are illnesses in the puerperium; and yet the germs are said to originate from the genital canal, and not from without.

Semmelweis and others since his time have emphasized the importance of ovular remains retained in the uterus, in the aetiology of puerperal disease; as dead material, these furnish a favorable culture-medium for the development of micro-organisms. Kaltenbach explains that the wandering in of germs takes place in those cases in which the remains hang into the germ-containing vagina; when this is not the case, he thinks they may remain without danger. Szabo does not think this is a sufficient explanation, but that the after-pains aspirate fluid into the uterus from that which collects in the posterior *cul-de-sac*. After careful consideration of his statistics, he concludes that if we prevent the presence of germs in the discharges the retained membranes are extruded without an elevation of temperature. Sixty-six per cent. of his cases of retained membranes had a normal puerperium. But since he had a normal puerperium in 80 per cent. of cases, the danger from retained fragments cannot be denied. This peril he obviates by destroying the germs of the lochia by the vaginal douche at the first rise of temperature; if this is not sufficient, the membranous fragments are removed. Decidual remains and their attached coagula, because of their more easy decomposition, appear to endanger more than do portions of the chorion and amnion.

It has often been thought that if a series of patients were to be observed whose labors would be allowed to progress without any internal examination, the subject of auto-infection would be cleared up. Ahlfeld treated fifteen cases in this manner, and had 60 per cent. illness. Along the same lines von Szabo gives a comprehensive table of sixty-two women who were delivered in the street. Fifty-four of these were not in any way touched; and of these, 79 per cent. had a normal puerperal period, 5 per cent. had one rise, and 14 per cent. had several elevations above 38.2° centigrade. There is also given a table of thirty cases of precipitate labor in the maternity, in which similar percentages were obtained. It must be remembered that 80 per cent. of the cases in general were normal. Then of this table it is remarked that if the women examined in the clinic in whom there is no endeavor made to avoid self-infection, and who are, besides, exposed to infection from without, become sick more seldom or not more frequently than those patients who, not being examined, are only subjected to self-infection, then it

is absolutely impossible that self-infection is the only cause of illness.

Another interesting fact which must be mentioned is the question respecting the puerperal period of women who are previously affected by gonorrhœa, but which cannot at present be pursued further than to refer to 95 cases observed by Kroner (*Cent. f. Gyn.*, 1888, 155), of whom only 15 had any disturbance in the puerperium; from this the conclusion is drawn that it is very questionable whether gonorrhœa frequently exerts an evil influence upon the puerperium. The puerperium of cases with children who had ophthalmia, von Szabo has noted, was not materially worse than that of patients in general during the corresponding time in the clinic. In regard to peri- and parametric exudate, von Szabo had 76 cases with purulent leucorrhœa, in many of whom condylomata and scars from former buboes were present; 67 per cent. had a normal puerperium. Still he has noted that the results are less favorable with an active gonorrhœa in the mother. Inflammations often become acute from trauma in gonorrhœal diseases of the adnexa. This circumstance, however, is not identical with the conception of a puerperal disease in consequence of self-infection; we can say, at most, that the labor and puerperium of a gonorrhœal woman gives rise to renewed gonorrhœal inflammation. It may be here remarked, also, that he had 25 cases of syphilis, in 52 per cent. of which the puerperium was normal. In thus hastily reviewing this article it has been necessary to omit even the briefest mention of many remarkably interesting points which have been demonstrated.

While the entire subject of auto-infection has remained in a measure quiescent for some years, the question has recently been again opened by Hofmeier (*Berlin klin. Wochenschr.*, 1898, No. 46), who defends the preliminary vaginal douche, which is the logical, practical consequence of a belief in auto-infection. This fact has inspired Dr. Eugene Peiser (*Arch. f. Gyn.*, lviii., 248) to report 2722 labors from the Maternity Hospital at Mannheim, under Prof. Mermann. Briefly stated, the patients here are treated with careful asepsis only, there is painstaking subjective antiseptis according to Furbringer, and the patients are usually examined, but not douched. Of the series of 2722 cases reported, 237 are counted out as not being suitable for

the present consideration, being cases of Caesarian section, cases examined or infected outside of the hospital, etc., so that 2485 cases remain. These are divided into three series. The first contains 1159 cases, which were examined by the regularly appointed midwife, or by the physician in charge, and of these, 3.1 per cent., had infection from without; 8 cases, or 0.69 per cent. had putrid infection from macerated fœtus, retention of membranes or placenta; 2 cases, = 0.7 per cent., had pathogenic foci from exudates, pyosalpinx, abscess of the vulvo-vaginal glands, etc. These ten cases are therefore ascribed to self-infection, according to the idea of Semmelweis. The second series, comprising 1239 cases, were examined by a midwife in training who is changed every six months. Infection from without was traced in 7.2 per cent.; 3 cases had putrid infection as above described, = 0.24 per cent.; 2 cases, = 0.16 per cent., had pathogenic foci. The third series contains 87 cases, and these were treated by the author and a midwife. The most exact subjective antisepsis was used. Infection was traced in 1.14 per cent.; 2 cases, = 2.29 per cent., had putrid intoxication, and no case had pathogenic foci.

From this it will be seen that in a series of 2485 cases there were 17 which may be attributed to self-infection according to the original idea, equalling 0.68 per cent. Analyzing this number, we find 13 cases, = 0.52 per cent., had putrid intoxication, and 4 cases had pathogenic foci as above indicated, = 0.16 per cent.; so that in this series, examined with exactness, there were but 68 cases in every 10,000 to which the term self-infection could in any sense be applied. It will probably require very little argument, and perhaps it will be necessary simply to call attention to the preponderating probability that 52 of these 68 cases in 10,000 were infected from without, when, with this presumption in mind, it is considered that in them there was present either dead fœtus with fever already before labor, or retention of ovular remains. Think how many opportunities for infection from without must have attended these cases! And so, if we look at the next figures, there were relatively 16 cases in 10,000 which had exudates in the pelvis, pyosalpinx, or abscesses about the vulva. Of these, it would probably be more correct to say they had an extension of an already existing disease. Now, in the light of all the circum-

stances which it has been possible to examine judicially, with reference to the question of auto-infection, would it not therefore be correct to say that here is a series of 2722 cases, some of which were complicated obstetric cases; a certain proportion of them had intercurrent diseases during parturition or the puerperium; approximately 5 per cent. had infection from without which it was possible to trace; and 0.52 per cent. had infection from without which it was *not* possible to trace?

We have now seen, from an examination of about 11,500 cases which have been collected and accurately tabulated for the demonstration of a number of important questions relating to the exact conditions of the female genitalia, especially with reference to auto-infection and the necessity for the vaginal douche, that the outcome is that auto-infection may only be acknowledged to occur with a rarity that is very near, indeed, to the vanishing point.

Let us now see to what result we will be conducted from an altogether different point of view, and from totally different methods of investigation. Since bacteriology has come to the aid of medicine, it has been invoked to lend its aid to the solution of some of the great questions of obstetrics and gynaecology. The exact bacterial condition of the vagina, both in the pregnant and non-pregnant state, has been studied in an astonishingly laborious manner. This obtains its importance because, as has been shown above, the original conception of self-infection has sustained a certain modification since its original promulgation; and in addition, as has been shown, a more accurate conception of the subject would be attained if cases suffering from a disease due to an infection from without, as, for instance, gonorrhœa or suppurative conditions in the pelvis, were not referred to as auto-infection, but were regarded as simply extension of a pre-existing infection. This is certainly a more accurate pathological concept. The phase of the subject then remaining for debate involves the exact bacterial condition of the vagina. The streptococcus pyogenes has been shown to cause the severe infections, and from it most danger is to be apprehended; therefore experiments are always directed toward determining its presence or absence in the series examined. Earlier bacterial examinations have furnished results which were often sadly contradictory, and it is but recently that

we may hope to have reached tenable ground. This is, perhaps, true with reference to the practical subject of auto-infection, though it is probable that other portions of the general subject of the vaginal secretion must be further investigated.

Renewed interest was awakened by Gonner (*Centralblatt für Gynecologie*, 1887, 444), who treated the subject according to modern bacteriological methods, although others before him had, for instance, studied the parasites of the female genitalia, and the action of the lochia when injected into the tissues of animals. Semmelweis also endeavored to confirm his discoveries concerning infection by animal experiments. Gonner prefaces his article by saying that Ahlfeld had stated that self-infection plays a greater rôle than is usually ascribed to it; practically, therefore, it was necessary not only to use subjective asepsis, but also to have regard to the disinfection of the person of the parturient. This incited Gonner to examine the genital secretion of pregnant women, to determine whether pathogenic germs were present which were likely to cause diseases of the puerperium. For this purpose he examined thirty-one cases of pregnant women who were mostly in the last stage of pregnancy. As a final result he came to the conclusion that there are no pathogenic germs in the cervical and vaginal secretion, and self-infection in the sense of Ahlfeld is not to be expected.

Shortly thereafter Doederlein found that the lochia in the uterus was sterile, but when taken from the vagina it contained micro-organisms in 75 per cent., and streptococci and staphylococci were also present. At the same time von Ott and Czerniewski (*Cent. f. Gyn.*, 1888, No. 50) also showed that the uterus is sterile, but von Ott was not able to further confirm Doederlein. Since then great interest has been awakened, but the results have varied considerably. I have made abstracts of a considerable number of reports of these experiments which it was my intention to insert in this place; but in order to keep this paper within the prescribed limits, only some bare results will be mentioned in the briefest possible manner, as Williams (*Amer. Jr. Obs.*, 1898, xxxviii., 809) has summarized them. Streptococci were found by the following in percentages varying from 4 to 27 per cent.: Burkhardt, Steffek, Doederlein, Burguburu, Vahle, Witte, Kottmann, Winter, Williams in 1893, and Walthard. On the other hand, since the experi-

ments of Gonner above mentioned, von Ott, Czerniewski, Thomen, Samschin, Kronig, Menge, Bumm, Williams in 1898, and recently Gonner, again, have shown that the vaginal secretion does not contain virulent streptococci.

It is unfortunate that the laborious work required by these bacteriological examinations has produced contrary results, especially since the clinical observations given above, and as obtained from numerous others, which cannot even be mentioned, have not been confirmed from every bacteriological examination, as is so greatly desirable. The methods employed in the bacteriological examinations have therefore been again scrutinized with a view to further developing them, and to discover possible errors in technique. In this connection Kronig (*Cent. f. Gyn.*, 1894, 4) has pointed out the important fact that most of those who had found pathogenic germs in the vaginal secretion had frequently demonstrated the staphylococcus albus and aureus, and only rarely the streptococcus pyogenes. *Per contra*, the lochia from the severer cases of puerperal fever "usually contained the streptococcus, and only in the rarest cases was present the staphylococcus aureus, never the albus. If it is assumed that the germs of the vaginal secretion may infect the uterine cavity during labor and the puerperium, the bacterial findings do not well correspond. Above all, the frequent occurrence of the staphylococcus albus must awaken doubt. Since it is just the albus that is found so very frequently upon the skin, the possibility is presented that this germ is first introduced into the vagina during the manipulations attending the removal of the vaginal secretion for examination." Heretofore the secretion has been obtained by means of a sterilized speculum, which of necessity must come into contact with the vulva, and thus carry in germs not before present in the vagina. Kronig used a sterilized glass tube of small diameter, so that the margin of the hymen could be passed without contact.

Williams became interested in this matter, and at once set about to repeat his work of 1893. He at first used the tube of Kronig, and then the apparatus devised by Menge, which consists of a metal tube 5 millimeters in diameter, fenestrated at the side of the closed end, and having within it another tube slipping in such a way that the fenestra may be closed, thereby permitting the withdrawal in its original state of any secretion

scraped from the upper vagina, after the tube had been introduced high up, without contact below. When the secretion obtained with these precautions was examined, Williams obtained results very different in 1898 from those made in 1893. He examined 92 cases (*Am. Jr. Gyn.*, xxxviii., 807), and in none of them was he able to demonstrate streptococci, and in only 3 was the staphylococcus epidermidis albus present. He then examines the methods employed by former investigators who obtained positive results, and shows that all of them used specula or large glass tubes, which were likely to carry into the vagina the germs not originally resident there, and thus all subsequent results were vitiated. This would explain the discrepancies which have interfered with bacterial examinations confirming clinical observations.

In conclusion, we may say that genital auto-infection is not sustained either by clinical observation or by bacterial research, and all suggestions of auto-infection tending to undermine the results obtainable by careful asepsis and subjective antisepsis should be steadfastly opposed.

REVIEW OF CASES OF BRIGHT'S DISEASE.

BY W. S. SEARLE, A.M., M.D., BROOKLYN, N. Y.

(Read before the Medical Society of Kings County, N. Y., December 12, 1899.)

REVIEWING my case-book, I find that, aside from those seen in consultation, I have treated, for a longer or shorter time, seventy-six cases of Bright's disease since I began to take especial interest in this malady, and keep a record of them.

Most of this number were chronic in character; only seven were acute, and none of the latter were sequelæ of scarlet fever or diphtheria.

Of the seventy-six, twenty-five soon passed out of my care for various reasons, and I am unaware of their fate. Fifteen improved to a variable extent, but have not wholly recovered, eleven have died, and twenty-five have been cured.

By cure I mean that for months and (in most instances) for years careful and repeated examinations have failed to detect

albumin, casts or kidney epithelia even in the sediment of the centrifuge.

Some of those classed as improved and some of those who have died were, or are, the victims of either inability or unwillingness to submit to the rigorous measures of a dietetic and hygienic nature which I deem essential, and a part of these I feel sure might have been restored to health if I could have controlled them in these particulars.

There is, however, one distinct class of patients whose nephritis the most enlightened and persistent effort of the physician and the most complete submission of the patient fail to reach, and a fatal result, sooner or later, is inevitable. I refer to those cases of chronic nephritis which are complicated by mitral stenosis or insufficiency. I have never cured a case of that description, nor do I ever expect to. Palliation is all we can look for, and mighty little of that.

Extreme caution in diagnosis is requisite here, however, since it is so easy to mistake anæmic murmurs for genuine abnormal valvular sounds, and, as you know, anæmia is very often present in Bright's disease.

Next to these heart cases in severity, danger and difficulty of cure, I rank those complicated by the presence of leucomaines—meaning by this those giving forth distinctively offensive odors.

In papers which I have had the privilege of presenting to you upon the subject of Bright's disease, heretofore, I have remarked upon this topic at more or less length; but the importance of the matter leads me to again briefly recur to it at the risk of repetition.

That an excess of effete and poisonous emanations not seldom occurs and may complicate any disease is, I think, indisputable, though few, if any, practitioners take it into account in prescribing for chronic cases.

But such excess is of especial moment in Bright's disease, since the kidneys are the main medium for the elimination of these leucomaines, and when they fail to perform their functions in this regard, these elements accumulate and prove most noxious.

Indeed, I am convinced that the retention of these leucomaines is a source of far greater danger to life than is the failure to excrete urea.

Some years ago I made several examinations of the urine of a lady of about seventy years of age. She voided about three quarts daily, of a specific gravity of only 1003. I found a minute quantity of albumin and very rarely hyaline casts. She had marked cardiac hypertrophy, and in cold weather especially she suffered much from pruritus, which was due to the excretion of urea through the skin. There was no offensive odor about her in any secretion. The exact amount of urea found in the urine I have forgotten, but it was extremely small.

She lived after this, and without treatment, for about four years, and never had any convulsive seizures. Nor is this experience at all phenomenal or uncommon. It is true this lady lived a very sheltered and retired life, and would doubtless have died much sooner had she been a man and exposed to climatic changes. But if the retention of urea were of the importance that was once supposed, I do not see how this and similar patients managed to escape death so long.

Do not misunderstand me, and suppose that I view the accumulation of urea in Bright's disease with indifference; but I feel sure that its importance has been greatly exaggerated, and that it is infinitely less noxious and lethal than are these leucomaines. Please consider that the production and excretion of urea in the healthy amounts to from three hundred to six hundred grains *per diem*, and that a reduction to one or two hundred a day is not at all uncommon. Then think of the months and years the patient often lives and endures such conditions with very little if any disturbance of function—so little, often, that he is wholly unaware that anything whatever ails him. Surely, the words “uræmia” and “uræmic convulsions” are misnomers and largely ignorant bugbears of the imagination. There are other and deeper sources for convulsion and death in Bright's disease, and as various as are the individuals who suffer from it and them.

To become convinced of this, one needs but to watch carefully two parallel cases which differ only in that one has an offensive odor and the other not. Still further, when, by means of protracted baths, we eliminate leucomaines, or by drugs modify, and even eradicate, the tendency to their formation, it becomes clearly evident to the intelligent physician that the

patient has, for a time at least, been rescued from imminent danger.

And this brings us to the important question whether, as a matter of fact, we can check or entirely cure the tendency to the production of leucomaines, and I am happy to say that in many instances it can be done. I believe it might be accomplished in every case if our *materia medica* was sufficiently developed in this direction, so that we could find the similar with accuracy and certainty. Unfortunately, this is not the case. Some observations of this character there are in our provings, and not seldom they are of immense value to the prescriber. But these observations are certainly no more reliable than are the bulk of the *materia medica*, and we are all sadly aware how fallacious and misleading that is when one comes to practically apply it.

From a consideration of these two of the more desperate forms of Bright's disease, it is pleasant to turn to one which I find to be very common—indeed, the most frequent of all—and yet one peculiarly amenable to treatment. I refer to that originally caused and kept up by lithæmia.

It has been common to speak of cases of this sort as “gouty kidney.” But gout is something more than lithæmia, or we should see more true gouty paroxysms than we do. I meet instances of lithæmia every day, but I never had half a dozen cases of true gout in all my forty years of practice. Gout, in my judgment, is lithæmia plus a specific leucomaine. Lithæmia is rather easily curable. One can scarcely say that of gout.

But this is a digression. Now about these cases of nephritis based on lithæmia. My experience is, that when you have gotten rid of the tendency to an excess of uric acid the nephritis will sometimes disappear of itself, and if you don't get rid of it you cannot cure the nephritis. It seems as if those much abused organs, the kidneys, resented the task of excreting uric acid, and would not do it until it had accumulated to a point beyond endurance.

In one respect, however, cases of this sort are unfortunately difficult of management. It is this: Lithæmia is largely favored by a sedentary life, and active exercise in the open air is one of the most efficient safeguards against it. On the other hand, we know that Bright's disease is always and essentially an in-

flammatory disease, and increase in the pulse-rate, necessarily induced by exercise, cannot fail to unfavorably affect any form of inflammation. And so we have to steer between Scylla and Charybdis in our management of these cases, and of two evils choose the least.

Acute forms of Bright's disease have not been common in my experience. Uncomplicated cases of this sort should always be cured, and generally are. Indeed, with proper hygiene and diet they often get well of themselves.

I shall not attempt, this evening, to enter into the details of cases and their medicinal treatment. It would be a review both tedious and uninteresting. I will only say that, so far as possible, I individualize my cases, and that the chief obstacle to cure lies in the especial difficulty in accomplishing this desideratum in this form of disease because of the paucity of symptoms. Nor can I add much in a general way to what I have already given you on previous occasions. Neither have I anything to deduct or discard from my ideas upon this head. My ideal for the patient is entire rest in bed in a room with a southern exposure, with open windows day and night, a protracted warm bath (not hot) every night, and a very simple diet, preferably of bananas and milk. The patient must have an equable temperature of air as far as possible, and must have cheerful and pleasant surroundings. Then, with the well-selected drugs, you will obtain the best and most speedy results. There is need of enlightened judgment in the adaptation of this programme to each individual case. Its effects must be studied, and the evils inseparable from this or any other course eliminated so far as possible. That the patient improves is good ground for persistence; that he fails, should insure a change more or less radical and complete. As in other things, we should, in the practice of our art, mix all our theories with a little common sense.

As at my last appearance here, I am on a still-hunt for some remedy or remedies that will dry up the springs of albumin after all other signs of nephritis have disappeared. I think, perhaps, in the necessity of the case—from the pathological changes induced by the inflammation—this sometimes cannot be done. And yet it is done in other instances; and if in some, why not in all? Just now I am trying geranin, the most uni-

versal remedy for diarrhœa I know of. But if it thus acts, as seems most likely, only from its astringent character, I expect to fail with it, as I have failed with tannin and gallic acid. I hope, however, there is something specific about its action, and that it will act on the capillaries of the kidneys as it does on those of the intestinal mucous membrane. I intend also to try *carbo veg.*, whose sphere is venous or passive congestion, and *carduus*, which has repute in varicosis. *Hammamelis*, with the same repute, has been tried, and has never helped my cases.

Finally, in respect to all the therapeusis of the kidneys, we must say that only slowly, with difficulty, and largely by analogy, must it be worked out.

Individualization is less practicable here than in any other disease, because of the paucity and often entire absence of distinctive symptoms, and without individualization our success as homœopaths is a matter of luck rather than of science.

THE CAUSES AND TREATMENT OF CYSTITIS.

BY. L. T. ASHCRAFT, A.M., M.D.

(Read, by invitation, before the Oxford Medical Club, September 1, 1899.)

Mr. President and Gentlemen: When our genial host honored me with an invitation to read a paper before this society, it was accompanied by a request to select a topic that might prove interesting. I beg to submit "The Causes and Treatment of Cystitis," trusting that the subject will meet with your approval. Only the commoner varieties affecting men will be discussed. Cystitis is caused by micro-organisms or their ptomaines, which effect an entrance through the urethra, and multiply in the bladder under conditions favorable to their growth. Micro-organisms gain access to the bladder through other channels. They frequently come from the rectum by way of the lymphatics, or directly through the blood-vessels, and often from a diseased kidney. But although the exciting causes are micro-organisms, they alone are insufficient to cause infection. Otherwise, the numbers which pass through the blood and lymphatics, eventually reaching the bladder, would

be sufficient to provoke cystitis in every individual. Conditions favorable to their development must exist. Such is furnished by anything that interferes with the function of the bladder, whether due to the ingestion of drugs, or to tumors or foreign bodies, or to impairment of the cord or central nervous system, or to involvement of the kidneys, or to obstructive conditions, such as hypertrophy of the prostate, strictured urethra and consequent retention of urine, or to abnormal conditions of the urine. To appreciate how these conditions favor bladder disease, it becomes necessary to slightly review the anatomy of the bladder. It is the reservoir for the urine. It is composed of four coats—a serous, a muscular, a cellular and a mucous coat. It is lined by several strata of transitional epithelium, which protect it. This epithelium is composed of three layers of cells, which are connected by a bridge-work of cells. So long as these are intact the bladder is a sound organ; but immediately they become invaded, its protection is destroyed, and absorption of septic material occurs. Of the causes enumerated, it is difficult to decide which predisposes most towards cystitis. They all produce congestion, thus impairing the vitality of the epithelium, and furnishing a favorable soil for the development of micro-organisms. Obstruction to the outflow of urine, as met with in hypertrophy of the prostate and tightly-strictured urethra, markedly predisposes toward congestion. As the urine trickles from the ureters, thus filling the bladder, its muscular coat alternately contracts and relaxes until its capacity is reached, when the tension of the walls calls forth the stimulus to urinate. If no obstruction is encountered, its function is unimpaired; but should any exist, contractions become more forcible and frequent and relaxations less. Naturally, hyperæmia results. The bladder expels only a portion of its contents. Its tissues lose the power of contractility, and atony results. Thus far, provided the urine that comes from the bladder is pure, cystitis is not established, since congestion alone is insufficient. The bladder does not become infected until instrumentation is practiced, when micro-organisms which exist in the urethra and upon unclean instruments are pushed into the bladder. I have been surprised more than once, while catheterizing for urinary retention, to note the clear character of the withdrawn urine. Even

with the microscope I have failed to detect micro-organisms. An exception to this, however, must be made in favor of urinary retention caused by bladder paralysis or locomotor ataxia, where the urine is retained for so long a time that it is impossible to get it to remain pure. Occasionally, in long-standing hypertrophy of the prostate, the bladder becomes sacculated, and pouches containing urine form behind the gland, or by hernia of its mucosa through its muscularis. Under such circumstances the urine which is retained eventually undergoes ammoniacal decomposition, thus favoring the growth of micro-organisms. Abnormal conditions of the urine, as met with in uric-acid and gouty conditions, favor cystitis by producing congestion. Turpentine and cantharis produce symptoms simulating bladder inflammation, but the annoyance disappears upon discontinuing these drugs. Stone of the bladder causes cystitis by injuring its epithelium. It will be seen that cystitis is suppurative.

Treatment.—That we may intelligently treat cystitis, it is necessary to recognize its symptoms. They are both local and constitutional. Local symptoms are most prominent, and consist of frequent micturition, localized pain, and modifications in the character of the urine, and in every case these are present in varying degrees. Constitutional symptoms arise from absorption of the septic products, and are rarely as pronounced as local changes.

The calls to urinate depend upon the degree of inflammation. In every instance the act is accomplished frequently. Occasionally, in severe cases, it may become necessary to void urine every few minutes. Here the contact of the urine with the inflamed bladder-walls takes the place of its tension, the normal stimulus to urinate. Forcible contractions and strangury are, under such circumstances, exceedingly distressing. In sub-acute and chronic conditions urination takes place more frequently during the day, or while exercising. Especially is this true in calculous cystitis, when the stone, if not encysted, comes in contact with the neck of the bladder. In hypertrophy of the prostate, urination occurs more frequently during the night. The exceptions to frequent urination in cystitis are encountered in atonic and paralytic conditions of the bladder. Pain is due to the contact of the urine with the inflamed mucous membrane. It increases with the degree of bladder inflammation,

and is always worse toward the end of urination. Pain is invariably present in acute cystitis, and may radiate to the perineum and thighs. Local tenderness is so marked that examinations, if instituted, occasion marked distress.

The urine in cystitis contains pus, various micro-organisms, ptomaines, ammonia, carbonic-acid gas, epithelial *débris*, blood and albumin. Pus is a constant symptom. In some instances, where it is imperceptible, it may be discovered by centrifugalizing the urine and examining microscopically. In acid urine the pus is evenly admixed, imparting a cloudy color; in ammoniacal decomposition it may be seen as stringy masses adhering to the bottom of the vessel. Blood is an occasional symptom, and results from intense congestion, and is therefore seen in very acute inflammation. It shades from bright red to brown, and accompanies calculus, neoplasms, tubercular and traumatic cystitis. In some cases it is possible to discover it only with the microscope. The quantity of albumin corresponds to the amount of blood and pus present. It usually occurs late. Ammoniacal decomposition is present in many cases, and pathognomonic. It results from the presence of microbes in the urine, whose action upon urea results in the formation of carbonate of ammonia. In this connection it is interesting to review the micro-organisms that are present in the urine of cystitis. It may be broadly asserted that they all have the power of causing ammoniacal decomposition. According to Moullin* and Albarran and Halle,† the organisms present are the *bacillus coli communis*, the *staphylococcus pyogenes albus*, *aureus et citreus*, the *streptococcus*, and the *uro bacillus liquefaciens septicus*. (At present we are not concerned with the bacilli, found in cystitis, due to special germs, such as the typhoid bacillus, the gonococcus, and the bacillus of Koch.) Acute cases are ushered in with a chill and moderate fever. The tongue becomes thickly coated, the bowels are either constipated or very loose. When all the coats of the bladder become involved, these symptoms become aggravated. Abscesses may even form in the prevesical space, or the kidneys become infected. In chronic cases constitutional symp-

* *Inflammation of the Bladder and Urinary Fever*, page 57.

† *A System of Genito-Urinary Diseases, Syphilology and Dermatology*, volume i., page 499. An article by Alexander.

toms are not so pronounced. Usually, however, there is lassitude, constipation and disorders of digestion.

Prophylaxis plays a very important rôle in the treatment of cystitis. Since it has been proven that infection usually occurs through the urinary channel, it behooves us to bring to a rapid termination any urethral disease, and to observe antiseptic precautions when operating upon this canal. Since cystitis is so often caused by the introduction of unclean instruments, I beg leave to submit a few suggestions concerning their use:

1. Scrub all catheters with warm water and soap.
2. Cleanse afterwards by allowing warm water to flow through them, then place in a sterilizer.
3. The sterilizer which I employ is of very simple construction. It consists of a one-quart graniteware kettle, with a cover. Inside this kettle is a metal tray, the bottom of which rests about two inches above that of the kettle. The tray is constructed as follows: It consists of a heavy cast iron base, a rim of thin sheet metal, pierced by holes to allow the free circulation of steam and water, a cover, and a wire handle to remove the tray from the kettle. The centre of the base is pierced by five small holes, in which are inserted five nozzles, over which the open ends of the catheters are applied. The catheters are then coiled around the bottom of the tray. About a pint of water is then placed in the kettle, and the covered tray is introduced; then the cover is placed over the kettle. As the water boils, steam and hot water are forced through the catheters, thus effectually sterilizing them.
4. After sterilization the catheters are placed in a sterile airtight jar. The one I use is 16 inches high by $3\frac{1}{4}$ inches in diameter. In the bottom of this jar I place two ounces of a 2 per cent. solution of formalin. The catheters are now ready for use.
5. No catheter after being removed should be returned to the jar unless subjected to this process of sterilization.
6. A catheter that is very flexible or slightly cracked, or that has been in daily use for over two weeks, should be thrown away.
7. All sounds and metal catheters should be washed in warm water and soap.
8. They should be placed in an ordinary sterilizing tray and boiled for three minutes, or they may be flamed off in alcohol. After this they are ready for use.

Before introducing any instrument into the urethra, the

prepuce and glans penis should be washed with soap and warm water, and the urethra irrigated with an antiseptic solution. These measures may appear to consume more time than is necessary, yet when one recognizes that micro-organisms are responsible for cystitis, and that they so often gain an entrance into the bladder by means of septic catheters, anything that prevents their growth should be regarded with distinct favor. Concerning the use of a lubricant, I have found that a preparation called lubri-chondrin answers all purposes. It is a jelly-like substance put up in sterilized collapsible tubes, and will remain aseptic in very high temperatures for a considerable time. The general treatment of cystitis should be directed first towards a removal of the cause, and then towards the control of symptoms. In calculus cystitis it is perhaps advisable to defer operation until the acute symptoms have subsided. In cystitis due to disease of the central nervous system the removal of the cause is practically impossible. All that can be done is to palliate. The phlegmasic affections of the urethra should receive the treatment outlined for their abortion.*

Retention of urine demands immediate operation either by catheterization, perineal or suprapubic cystotomy. Strictures should be dilated or cut, although dilatation should be discarded in favor of urethrotomy where cystitis is aggravated by such treatment. Hypertrophy of the prostate—one of the most prolific causes of cystitis—should receive appropriate treatment. In connection with this subject it is interesting to note that Bottini's operation promises to give good results. Conditions which favor the occurrence of congestion of the prostatic urethra should be avoided. The treatment of cystitis, however, is largely surgical, although medical treatment is indispensable in the majority of cases. Each case must be judged upon its merits. The causes of cystitis are so numerous that it is impossible to lay down any rules which would be applicable to all cases. In very acute cases rest in bed is imperative, and the patient should be kept there until improved. The diet should be nourishing but light. Alcohol should be positively interdicted. Pain is an annoying feature, and may be relieved by applying hot stupes to the suprapubic region. In many cases,

* See the treatment of specific urethritis, a plea for abortive methods, by L. T. Ashcraft, A.M., M.D.—*HAHNEMANNIAN MONTHLY*, June, 1896.

however, an anodyne may have to be administered. This may be given in the form of a one-grain opium suppository, which is inserted into the rectum. Hot sitz-baths are very grateful, and may be repeated frequently. The remedies that have proven most effectual in acute cases are *vesicaria*, *terebinthia*, *cantharis*, *aconite* and *belladonna*. In highly acid urine *citrate of potash* is indicated. Diarrhœa or constipation, if present, should be corrected, since they cause congestion and favor the migration of the bacillus coli communis, which is so prevalent in the intestinal tract. I am opposed to local treatment of any kind in acute cases. In chronic forms, however, treatment is largely local, although I have obtained excellent results from *kali bichromicum*, *argentum nitricum* and *sulphur* in conjunction with local measures. When the bladder cannot empty itself, or when the urine is highly concentrated or infected, I attempt to control infection by the administration after each meal of 5 grains of urotropin. In cystitis independent of obstruction, where the septic organisms multiply more rapidly than they are carried away, their growth must be checked by local treatment. This can sometimes be accomplished by instillation or intra-vesical irrigation. Instillation is performed by means of a Keyes-Ultzmann syringe, depositing upon the neck of the bladder five drops of a 1 per cent. solution of nitrate of silver. It has the disadvantage of causing some inflammatory reaction, which, however, subsides after the first urination. This procedure I repeat every four days. This method possesses only one advantage, viz., that of depositing a concentrated solution upon the diseased surface. Intravesical irrigation is more efficacious because:

1. It brings an antiseptic in contact with every portion of the bladder mucous membrane.
2. It relieves congestion.
3. It may be practiced daily.
4. It washes the diseased epithelium and micro-organisms from the bladder.
5. In the absence of obstructive disease the bladder may readily be flushed without the use of a catheter, thus doing away with one of the chief causes of infection.

The flow of fluid from an ordinary fountain-syringe sus-

pended at a height of nine feet will be sufficient to overcome the resistance offered by the compressor muscle. Of course this method is not indicated in bladder paralysis. Here it is better to use a soft catheter and a hand-syringe. I usually, at a sitting, inject 4 ounces of any of these antiseptics: a saturated solution of boracic acid, 1 to 4000 permanganate of potash, 1 to 20,000 bichloride of mercury, 1 to 5000 nitrate of silver. If the bladder cannot empty itself, it must be made to do so either through the urethra or by artificial methods. It may be emptied through the urethra by daily or systematic catheterization, or by tying-in a catheter, or it may be opened and drained by the perinæum or above the pubes. In mild cases daily catheterization may be practiced, always employing a smooth, flexible catheter where practicable. Where the walls of the bladder are but slightly affected, tying-in a catheter is always attended with good results, although it may promote a traumatic urethritis. Should these measures fail to cure, more effectual drainage is indicated. When the patient is confined to bed, perineal cystotomy should be instituted. It favors drainage by gravity. It is not necessary to enter into the technique of this operation, except to mention the necessity for forcibly dilating the sphincter. This gives that much-overworked muscle a rest and helps to restore its lost tone. The largest-size soft-rubber catheter should be tied in the bladder, and the urine allowed to drain into a receptacle. By this method the bladder may be washed frequently. As a rule, it is not necessary to drain for more than two weeks. Suprapubic cystotomy possesses many advantages, since by this method the bladder interior may be inspected for ulcers, foreign bodies and post-prostatic pouches. Also drainage can be made permanent by slipping rubber plates over the catheters and strapping them around the waist. Bladder washings are also made possible. Occasionally urinary infiltration results from this operation, which may be avoided by first cutting down to the bladder, and then, within a few days, opening that organ. In two cases I have found it necessary to drain the bladder by both methods, but most of my cases have been benefited by perineal cystotomy.

ADENOID VEGETATIONS AND A PLEA FOR THEIR EARLY REMOVAL.

BY H. S. WEAVER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pa., Philadelphia, September, 1899.)

“ADENOID vegetations” is the common term used to describe a true hypertrophy of the normal lymphoid structures in the vault of the pharynx and adjacent parts.

This glandular hypertrophy is essentially a disease of childhood, occurring usually between the ages of four and twelve years.

Tuberculosis, syphilis and scrofula all predispose to this affection; probably the tubercular or scrofulous diathesis is more frequently found, and with it the tendency to glandular involvement in all parts of the body, giving rise to the malnutrition and lack of development so characteristic of adenoid disease. Heredity no doubt is an important factor in the ætiology of this affection—often several cases occurring in the same family, due, in all probability, to the inherited diathesis, or possibly to exposure to the same unsanitary conditions.

This tendency to hypertrophy, the result of inflammatory changes under the stimulus of oft-repeated colds, occurs more frequently in children because all glandular structures are more prone to these morbid changes in early youth. Occasionally it is found in young babes, and not infrequently in young adults. I saw one case in a babe of three months which presented the identical symptoms of inherited syphilis, with the characteristic nose involvement found at that age. No specific history could be obtained, and a digital examination of the naso-pharynx revealed the presence of a number of adenoid vegetations.

When these hypertrophies occur in young adults, I believe they have existed in the majority of cases since childhood, and only under the stimulus of some inflammatory process in this region has the hypertrophy increased to a sufficient size to cause distress, and upon making an examination the true condition is recognized.

The exanthemata have a great tendency to produce inflammatory changes in these parts, and consequently oft-times give

rise to the starting-point of this hypertrophy, or, if this hypertrophy be present, stimulate the process with renewed energy.

Adenoid vegetations may occur with or without nasal complications, although ordinarily there is associated with it a hypertrophic rhinitis with a true or pseudo-hypertrophy of the lower turbinated bodies; this is due to the repeated acute catarrhal colds which at times are the only symptoms that lead to a consultation with a physician.

The pathology consists of a hypertrophy of the normal histological elements of the mucosa in the vault of the pharynx and adjacent parts. The adenoid hypertrophy differs from that of the faucial tonsils chiefly in having less connective tissue, and consequently is much softer and more prone to atrophy after puberty. The tissue under the microscope shows a covering of stratified columnar epithelium more or less deprived of ciliae, with deep furrows, which gives the mass a lobulated appearance. "These masses are made up of lymphoid cells, arranged in the usual node form, with internodal areas sparsely supplied with a low grade of connective tissue, which, however, has a fairly abundant blood supply." The soft, jelly-like consistency is due to the preponderance of lymphoid cells, and is familiarly spoken of as "feeling like a bunch of earth-worms."

Probably the most striking symptom is the pinched facial expression so characteristic of adenoid disease, the open mouth, shortened upper lip, with lines running from the alæ nasi to the corners of the mouth, protruding incisors, a broadening and flattening of the nose, and dulled expression from the eyes. These symptoms, which are almost pathognomonic of this disease, are not so detrimental to the life and development of the child as the deleterious effects adenoids have on the nervous system. The depressing influences caused by pressure on the nerve-endings in the vault of the pharynx by these abnormal growths is quite severe, rendering the child nervous, sleepless, with sudden starting during sleep as though from troubled dreams; consequently the child is delicate, pale, undeveloped, with small appetite, and in a favorable condition to contract any acute disease with which it may come in contact.

Most of the ear conditions found in children under twelve years are, I believe, referable to disease found in the post-nasal space, chiefly lymphoid hypertrophy of the pharyngeal tonsil.

These ear complications develop so insidiously that they are often overlooked. If they are not promptly recognized and careful treatment instituted, the child is in great danger of impairment or permanent loss of one of its most important faculties. The symptoms are mostly a chronic catarrhal otitis, or a chronic purulent otitis with acute exacerbations; the former resulting from a simple hyperæmia or congestion of the mucous membrane of the Eustachian tube and middle ear, and the latter from a more extended inflammatory action on the membranes and deeper tissues of these organs.

This hyperæmia and inflammation of the mucous membrane is caused, in the majority of cases, by a deficient nasal respiration, or an obstruction to or pressure upon the Eustachian orifices, with consequent rarefaction of the air in these parts. If these symptoms are not promptly relieved, the patient develops a retracted membrani tympani, and later atrophy of the same, with ankylosis of some of the ossicles, causing a permanent impairment of the organ. Discharge of a muco-pus is a prominent symptom, and it is frequently swallowed because of the post-nasal occlusion.

An alteration in the voice becomes apparent, the extent depending upon the size and location of the growth. It is characterized as a dead, non-resonant voice, with marked nasal intonations, similar to the voice of one suffering from severe cold in the head. To have a clear, ringing voice in all the registers, one must have a clear, normal larynx, pharynx, naso-pharynx and nasal fossa; and for pure tones in the middle or speaking register, the dome or arch of the upper pharynx must be symmetrical, hard and resonant. In adenoid disease these growths destroy the contour of the pharynx, and present a flabby mass, irregular in shape, with little or no resonant qualities; consequently the voice becomes the dead, unnatural one so characteristic of this disease.

Mouth breathing is a prominent symptom, found in most cases constantly, and in others only at night, or during acute colds. When the growth is small, and the nasal obstruction not marked, the voluntary muscular action will enable normal nasal respiration during working hours; but from the relaxing influences of sleep the muscular effort is decreased, the breathing becomes labored, and the mouth opens to allow the freest possible passage for the air to enter the lungs.

The mouth breathing is the difficult thing to overcome after operation, unless performed quite early, before the habit is so firmly established; otherwise, some mechanical device must be used to aid the passage of air through the natural channels until the normal respiratory function is re-established.

The facial expression, deafness, discharge, altered voice, mouth breathing, cough, and delicate, illy-nurtured constitution of the child will ordinarily be sufficient for a correct diagnosis, but a positive one cannot be made until a digital or rhinoscopic examination is made, revealing to the finger or the eye the presence of the growth. In young children it is difficult, and at times impossible, to obtain a satisfactory view of the vault by the rhinoscopic mirror; so a digital examination is necessary, first, to make a positive diagnosis, and, second, to determine the size and location of the growth.

By the rhinoscopic mirror a good view of the vault and its contents may be obtained, providing the patient has sufficient control of the throat-muscles to relax the soft palate. To accomplish this the tongue is depressed and the mirror placed well back and low down on the base of the tongue, bringing into view the posterior wall of the pharynx. The handle of the mirror is gradually lowered, bringing progressively into view the surface of the vault until the anterior portion is reached, revealing the nasal septum. The vault will present, instead of a round, dome-like cavity, an irregular, reddish-gray mass, hanging down, and to some degree obstructing the view of the nasal cavities posteriorly. In a number of cases the mass is adherent to the Eustachian cushions, presenting an irregular surface, with deep furrows running antero-posteriorly through it. The lower pharynx almost invariably discloses a condition of chronic follicular pharyngitis. In nearly all cases of adenoid disease there is associated with it a hypertrophy of the faucial tonsils.

The treatment of adenoids should be instituted early, and the parents told of the many dangers to which the child is subjected should this be delayed or neglected. The underlying diathesis should be sought and remedied; the general health must be sustained by nourishing foods, fresh air, moderate amount of exercise, and tonics which will aid tissue formation.

Remedies are of undoubted service, and will sometimes cure,

or at least relieve, many of the symptoms; but their action is slow, and they should not be relied upon solely when the normal functions of the adjacent organs are interfered with, because a delay sufficiently long to obtain a remedial action may cause permanent injury to or loss of these functions. When selecting the internal remedies, the totality of the symptoms and the pathological condition should be taken into consideration. Those chiefly indicated are: calc. phos., calc. iod., sang. can., iodine, silicea, kali mur., kali sulph., and baryta iod.

The local applications to the vault will relieve many of the distressing symptoms, and at times permanently decrease the growth, but the milder ones only are applicable, because of the danger of the preparation coming in contact with the surrounding parts. Chromic acid should not be used unless the rhinoscopic mirror and a protected probe be used to place it accurately on the growth. The galvano cautery is a more efficient means of treatment, but only applicable in adults where a good view of the naso-pharynx can be obtained. Great care should be exercised in its use. First the growth must be cocainized, then, by the aid of the rhinoscope, the blade of a bent electro placed into position cold, and the current turned on, making two or three punctures at one sitting; this should not be repeated in less than a week or ten days.

In the great majority of cases the most satisfactory treatment is the complete removal of the adenoid tissue by surgical procedure, the time of the operation depending upon the condition of the patient.

In children and very nervous adults the operation is best performed under a general anæsthetic, not allowing the patient to be so completely under its influence as to abolish all the reflexes, thus reducing to a minimum the danger of asphyxia from inspiration of blood into the larynx. With children, where there are no contra-indications, I prefer chloroform, because of the lessened mucous secretion.

There are numerous methods and devices for the removal of these exuberant granulations, which are all applicable in given cases. The nail on the index finger of the operator is all that is necessary in many young patients, where the growth is soft and friable. The artificial finger-tip is useful, but must be used with greater care than the natural nail, because of the

absence of the delicate sense of touch, which increases the possibility of injury to the surrounding structures. In the operation as ordinarily performed the patient is anæsthetized, the shoulders are raised, the head slightly dependent, preventing the flow of blood into the pharynx, and later being drawn into the larynx by inspiration; the mouth-gag is placed between the teeth, the index finger of the left hand is introduced into the post-nasal space, and all the growths definitely located. The tongue is depressed and the Gostein forceps inserted back of the soft palate, grasping the tissue and tearing it away, care being exercised not to grasp the Eustachian cushions or posterior end of the nasal septum and injuring them. The forceps must be introduced several times in order to remove all the growths; frequent examinations of the vault must be made by the index finger, to see that no tissue remains; then insert the sharp curette to remove the remnants not torn away by the forceps, using no undue force.

At times the bleeding is quite profuse, necessitating a stopping of the operation for a few moments in order to mop out the blood, sometimes requiring pressure to the naso-pharynx with cotton mops to arrest hæmorrhage, after which the operation may be continued until completed. After thorough removal the bleeding usually ceases very promptly; if not, a saturated solution of tannic acid and water may be applied to the naso-pharynx by cotton mops, holding them firmly against the bleeding surfaces.

Should these milder measures fail, then firmly pack the post-nasal space with gauze, not allowing it to remain more than from twelve to twenty-four hours, because of the danger to septic involvement of the middle ear through the Eustachian tubes.

The nostrils should be gently squeezed, freeing them from the blood which they contain, finally mopping them with cotton fastened on a straight probe, which is passed through into the naso-pharynx. All of the clotted blood should be removed from the post-nasal space, lessening the danger to septic involvement.

The patient must be kept in bed until all the effects of the anæsthetic have passed off, usually from twelve to twenty-four hours. At the end of this time, if no complications have arisen,

the patient may be allowed up and around the room. If there is no discharge or odor, or rise in temperature, or symptoms of ear involvement, the less done to the parts in the way of spraying, the better; should any of these symptoms be present, a mild alkaline solution sprayed through the nostrils to cleanse the parts will be sufficient.

We so often hear it said among the laity, and occasionally by physicians, when attention is called to these conditions in children: "I would not have anything done; the child will grow out of it." It is true, children sometimes outgrow some of the symptoms, but at the same time they grow into others far more serious, and which handicap them through life. How often are cases seen where operation has been neglected or deferred from time to time, with the forlorn hope that nature would bring about a normal atrophy at puberty. In the meantime irreparable changes have taken place in the organs of hearing, and the normal development of the naso-pharynx has been impeded. There are some cases where the growths do atrophy after puberty, but rarely entirely, and, when they are sufficiently large to interfere with normal functions, create an irritation which produces a post-nasal catarrhal condition, so chronic in its character that later treatment becomes entirely ineffectual, all of which could have been avoided by early operation.

It is also true that operation is not always required, but in a great number of cases it is an absolute necessity, and in no branch of medicine are the results more gratifying than from the early removal of these naso-pharyngeal growths.

The once listless, unobservant, undeveloped, sickly, pale, emaciated child seems to have had a new birth, awakening the dormant faculties; the expression brightens, the vacant stare rapidly disappears, the mouth breathing more gradually, phonation becomes clear and distinct, nervousness disappears, and with the return of hearing the previously dulled mental faculties rebound with such rapidity that the parents, and oftentimes the physician, are astonished at the marvelous result.

CALCAREA IN DISEASES OF THE GLANDS.—Swelling and induration of the submaxillary, axillary and inguinal glands, also of the cervical, parotid and facial glands, especially when there is otorrhœa and hard hearing. Also for "cold swellings" and mesenteric involvement.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

FOUR YEARS MEDICAL STUDY.

THE edict lately promulgated by the Medical Council of Pennsylvania, requiring four years of exclusive medical study before a candidate is entitled to make application for a license to practice, has, as was natural, aroused much criticism, to which we propose herewith to add our quota.

Before doing so we wish to make our position clear, and to remove all possibility of being misunderstood. We believe in a high standard of medical education, the highest attainable under existing circumstances. We believe also that physicians should have, where practicable, the widest possible culture and education as the basis of their medical training. We believe that four years is none too long a time to devote to the study of medicine, and that he who thinks that this latter is capable of being completed even in that time is as wide of the mark as he who thinks that the length of time devoted to a study is an infallible criterion of the proficiency acquired. The true physician never completes his studies; the college can give only a mental training, and a basis of observed facts and probable theories upon which each one must labor to erect his own superstructure. A long time to be spent in preparing the foundation is, therefore, desirable; but the desirable is not always practicable, and an attempt to obtain even the desirable may none the less be ill-advised, or even unjust.

Our views in regard to the origin of the whole State examination movement and the factors which have contributed to its present, we hope, short-lived success, are known, and their historical correctness cannot be denied. Let us trace the history of this latest move of the Medical Council.

Through the partial confession of a disgruntled conspirator, and therefore would-be reformer, the fact that unfair means had been used to enable certain candidates to pass successful

examinations before the State Board came to the ears of this body, and unfortunately of the newspapers, too. The former, as in duty bound, investigated the matter, and gave out a report which, while not entirely satisfactory, was at least calculated to keep the scandal from spreading, at the same time that it adopted a plan which, if carried out, would render trickery and deception in the future impossible. Unfortunately the *Philadelphia Press* saw the possibility of making political capital out of that which concerned directly only the deceived Medical Board and the medical profession, and any one who read this paper in the beginning of this disturbance can recall how the whole matter was made to fit into the anti-Quay agitation, and it almost appeared as if Quay had directly instigated the action of the State printer or his subordinates. For several days the columns of this enterprising sheet teemed with communications from unknown and hitherto unheard-of physicians in every corner of the State, deploring the scandal, but more particularly praising the *Press* for its activity in unearthing and ferreting out all the details. Having thus artificially created a medical "public sentiment" which seemed to demand a more thorough examination on the part of the Medical Council, that body found itself compelled, as the reporters say, "to probe the matter to the bottom," no matter what mud and slime and stench might arise. Having thus effectually stirred up the profession, the political aspect has been allowed to drop out of sight, and it is now a purely medical matter. Singularly enough, just about this same time, as if to emphasize its virtuous intentions, we will not suppose also to divert some attention from the manifest fallibility of the results of State examinations, the Medical Council issues its edict that four years of exclusive medical study in a medical college will be required of all future candidates for license to practice.

We maintain that such action is illegal and illogical. Bro. H. C. Wood (*Philadelphia Medical Journal*) says, with unusual modesty, "I do not feel justified in legally challenging the action of a board of which the Attorney-General of the State is a member."

Were the membership of a lawyer on a board a guarantee that none of its acts could be illegal, then would one of the most fruitful sources of legal emoluments be destroyed forever.

We venture to say that in framing its resolution the Medical Council never consulted the Attorney-General as to its legality, nor as to its correct formulation, to judge from the ambiguity of its wording. The Act of Assembly demands, as stated by Dr. Beates (*Philadelphia Medical Journal*), that the Medical Council must have proof that the candidates for examination for license to practice have studied medicine at least four full years, three of which shall have been pursued in legally incorporated medical institutions. Now, if the English language is capable of being used intelligently to express ideas, then these words must mean that one year of the study of medicine may be pursued elsewhere than in a medical institution. Surely it is, then, an illegal act for the Medical Council to go back of the Act whereby it was created and demand that all four years of medical study shall have been pursued in a medical institution. The illogical character of the whole matter becomes evident when Dr. Beates says: "The science of chemistry, the science of anatomy, the science of physiology, and such subdivisions as embryology and histology, must not be confounded with the medical aspects of these several departments of scientific culture." Either the narrower medical aspect of these sciences is contrasted with and preferred to the broader and more thorough study of them in colleges not medical, or they are themselves to be regarded as preparatory to the study of medicine. The former cannot surely be his meaning, and the latter is forbidden by the Act. If they are preparatory, then have the Medical Examiners nothing to do with them, and their examinations have been pure instances of "meddlesome midwifery." But the Act compels them to hold examinations in anatomy (not the medical aspect of anatomy), in physiology (not the medical aspect of physiology), and in chemistry (not the medical aspect of chemistry), and these are, therefore, not preparatory studies, but medical studies, of the proficiency in which, as signs of the fitness of the candidate to practice medicine and surgery, the State Board has been constituted a judge. What Dr. Beates calls a "short cut to degrees" we would call a valuable economy of time; for if the student does not acquire the "medical aspect" of the studies referred to by him in his three years in a medical college, even if he has gained in the first year of the required four only a scientific knowledge of

them, then is their universal recognition as the fundamental basis of all medicine a delusion and a snare.

We agree perfectly with him that the law has nothing to do with the medical colleges. As he says, "The law is (*ostensibly*—Eds.) for the protection of the people against unfit practitioners of medicine and surgery." Has that purpose been carried out? Are the means adequate or even reasonably adapted to further that end? We answer emphatically, No. Have the sales of proprietary medicines and nostrums diminished? Are there any fewer itinerant healers? Is counter-prescribing less common? Are the Christian Scientists, osteopaths, and such ilk, interfered with? Here, truly, Where ignorance is bliss 'tis folly to be wise. The one who knows nothing is allowed unhindered to ply his trade, while he who attempts to gain knowledge first must bear the full brunt of the law's demands. The poor, dear, innocent, harmless, gullible public must at all hazards be protected from treatment by those who do not know thoroughly the history of the United States and the habits of the aborigines; who do not know how to paragraph a composition, or to convert poetry into prose—knowledge universally recognized as indispensable to the intelligent study of medicine—while it may allow itself to be treated, so long as it is not "to the death," by those who do not know what relation the humerus bears to the "funny bone," or whether the sternum is an anatomical entity or a latinized name for a rather undefined locality. Let the carriers-out of the law turn their attention to limiting the evil against which the law was directed, and cease to impose further burdens upon those who manifest a desire to fit themselves to treat *lege artis* the poor, suffering public, and they will gain the confidence and sympathy of the profession.

What effects must necessarily follow the present mode of procedure? The knowledge of the physician and the time spent in acquiring it are his invested capital, from which he has a right to expect an adequate return. The trades' union spirit which so frequently crops out in this movement for a higher standard of medical education will have the same results that it has had in the trades—it will lessen the number of those able to enter the profession, and will increase the wages (heaven save the mark!) of those who do enter. The poor, dear public will thereby be only the more surely driven to seek

the advertised nostrum, the consultation-free, twenty-five-cents-for-the-medicine doctor, or the dispensaries where a ten-cent fee, given for the medicine, serves adequately to preserve for it what little self-respect it has retained.

With a feeling of hope and our heartiest approval we quote the final words of Dr. Beates, and recommend them to the earnest study of the enthusiastic defenders of medical legislation: "May the day be speeded when the fair name of medicine will no longer have upon its temples and disciples that stigma which is perpetuated by the existence of medical legislation, medical councils and State boards of medical examiners, and when the faithfully discharged duties and attached responsibilities of the medical school and college will determine the natural death of medical law." We differ only in presaging not a natural death, but one from locomotor ataxia, serious symptoms of which have been manifested throughout its whole existence. We feel hopeful of the future, because so influential a man as Dr. Beates recognizes in the above quotation that true, rational, intelligent improvement in medical education can be brought about solely by the action of the colleges themselves, evidences of which healthy activity were manifest long before the artificial and illogical stimulus of medical boards was applied.

WHO SHALL MAKE THE DEATH-CERTIFICATE?

THE duties of the practitioner of medicine originally included the examination of the patient, the diagnosis and prognosis of his disease, the treatment of his condition, and, in case death occurred, the certification of his death and of its cause. In recent years the function, though not the responsibility, of diagnosis (in cases of infectious disease) has been assumed by local sanitary boards, and usually assigned to a subordinate official who, for the purposes of the board, is dubbed with the title of "bacteriologist." His diagnoses are made at "long range;" but, while they do sometimes hit the bull's-eye, they do not often shoot straight except in cases in which the "clinical indications" are in themselves sufficient to render a clinical diagnosis sufficiently reliable without the bacteriologist's aid.

Just now it is being proposed to still further diminish the province of the practitioner by taking from him the authority to decide ultimately the fact of the patient's death. The New York Society of Medical Jurisprudence, appalled, perhaps, by the multitudes of people annually buried alive in that city—though each one is usually buried but once, and not “annually”—has addressed a communication to the health authorities suggesting that hereafter “only authorized practitioners of medicine should decide whether a person is dead or not.” The communication further says: “As it is now, any person, without any medical knowledge or trained capacity of observation, who happens to be present when a person stops breathing, can report him to be dead,” etc. That's as it is in New York. Here in some of our Pennsylvania districts we manage better. In certain parts of this State, when a man dies we tumble him into a hole and cover him up, and the Board of Health neither knows nor cares anything about it. We don't ask any “person” to report, and the doctor has no need to bother himself as to whether the man is really dead or is only playing possum to get the life insurance, or to procure a separation from his wife without feeing the lawyers.

But now it is being urged by the afore-mentioned Society that not even the death-certificate of the trained expert shall be accepted by the health authorities without the addition thereto of a grain of salt. It is insisted that the certificate shall state that the physician who issues it has personally examined the body after death, and before any preserving or embalming process is applied to it—a most wise recommendation—and that he shall also write either “Yes” or “No” to certain interrogatories bearing upon the question of actual death. These questions are: “Has respiration ceased permanently?” “Has the heart's pulsation ceased permanently?” “Is there discoloration from blood stasis of the most dependent portions?” “Are the corneas glazed?” “Is there rigor mortis?” “Are there indications of putrefaction?”

This latter portion of the Society's recommendation is as unwise as the former portion is judicious and needful. Disguised as it may be, its real effect is to assert that physicians are not qualified to certify conclusively to the fact of death, but should be required to present the evidences of death to the Health-

Board, which would then proceed—that is, the Board's clerk would proceed—to determine whether the evidence justifies the supposition of death. It is merely one more attempt to deprive the medical profession of its proper function and transfer it to a body of laymen, or perhaps of a body composed of both laymen and physicians. Health-board diagnosis, health-board examinations to determine qualification for practice, and health-board control of medical education, are to be followed by health-board certification of death. If we go on in the same direction, health-board law is destined to become as famous as was olden-time “Crownor’s ’quest law.”

The physician accustomed to the new order and method of things will soon acquire a properly profound distrust of his own competency, and will hesitate long and consider carefully before submitting his own verdict of death to the discriminating inspection of the boy who clerks it in the Registration Office. That “higher court” may “reverse” him and hold him up to public scorn. Then, when he becomes duly impressed with a sense of his own ignorance and incapacity, we can imagine him sitting at his desk engaged in filling out a certificate. “Has respiration ceased permanently?” “I guess so,” he writes; “it stopped seven hours ago and shows no signs of starting up again.” “Has the heart’s pulsation ceased permanently?” “Well, it stopped about the same time that respiration did; but I really can’t say whether the cessation is ‘permanent’ or not. The heart is deceitful above all things and desperately wicked, and there’s no knowing what it might do.” “Are the corneas glazed?” “Don’t know; couldn’t see through the pennies.” “Is there rigor mortis?” “Afraid to say; he was always set in his ways, anyhow.” “Are there indications of putrefaction?” “Am unable to decide. When I laparotomized him yesterday for septic peritonitis his entire intestine was gangrenous. Can’t say just how it is now; he’s been sewed up.” Then, under the head of “Remarks” he proceeds to add: “I can confidently state the cause of death, the mode of death and the time of death, but am not competent to certify the fact of death. I give you the ‘symptoms’ and your office-boy must do the rest.”

If the physician is to be required to submit his reasons for supposing the patient to be dead, and said reasons are to be

adjudicated by a body of laymen, or even by a body of physicians, who never saw the patient either dead or alive, we shall find that practitioners will naturally adopt conservative methods, and will politely request the officials of the health-board to make the necessary inspection and decide for themselves—if they can—whether the corpse is dead or alive. They will certainly be warranted in refusing a certificate which they know is to be accepted or rejected at the hands of men who are far less safe judges of the matter in hand than they are themselves.

It is possible—*barely* possible—that even in modern days, a few—a *very* few—persons have been embalmed alive or buried alive; but the remedy proposed by the Society of Medical Jurisprudence is not calculated to diminish the number of the unfortunate victims.

ONE HUNDRED VAGINAL HYSTERECTOMIES FOR PELVIC INFLAMMATION WITHOUT A DEATH. —(Pryor.)—His method of operating is to incise the vaginal mucosa anteriorly and posteriorly over the cervix, where the peritonæum is reflected from the uterus, leaving a strip of mucous membrane an eighth of an inch wide on either side. The finger dissects a small space along the median posterior surface of the uterus up to the fundus for the insertion of a director at a later stage of the operation. The anterior peritoneal pouch is then opened and the bladder held up by a narrow retractor. The uterus is then bisected anteriorly in the median line, and volsella forceps evert and roll out from under the bladder the cut halves of the anterior uterine wall. The grooved director is then inserted posteriorly and the posterior wall of the uterus is split, completing the bisection of the uterus. No attempt at hæmorrhage has been made. Each half of the uterus and its appendage is now treated separately. A pair of traction forceps is attached to the fundus, and a pair of bullet forceps to the cervix of each segment. The right half is pushed up in the pelvis and the left half brought down. The retractors are withdrawn, and the left hand is introduced in the pelvis to separate the adhesions and free the adnexa. This is repeated on the opposite side. Forceps are then applied on the upper border of the broad ligament from above downward, the ligament cut to the point of the forceps, and another forceps applied in like manner and so as to include the uterine artery. The right half of the uterus is then cut away, with its appendage. The left half is then treated in like manner, leaving four forceps on as many extra-peritoneal stumps. The pelvis is wiped dry. An abundance of gauze is carefully and snugly applied around the forceps and over their points with a strip of iodoform gauze between the forceps on each side. The sphincter ani is stretched. The forceps are removed in two days. —*American Journal of Obstetrics*, May, 1899.

George R. Southwick, M.D.

GLEANINGS.

THE INTERMITTENT FORM OF FAMILIAL ALBUMINURIA.—Dr. Loude states that the influence of heredity in albuminuria, the coexistence of several cases of this morbid state in several members of the same family, are facts on which several writers have insisted. The word albuminuria has a very varied pathological significance. Accepting the definition of the familial disease of Adams, he asserts that there is an intermittent form of familial albuminuria. It is more frequent in youths and forms part of a morbid whole: renal disturbances, gastric, hepatic, nervous, and general disturbances. Late or early, it is always in relation with a disturbed development and a certain degree of degeneration.

It appears particularly during puberty and other critical periods, as during the first pregnancy, for example. It may be possibly one of the origins of a chronic nephritis par excellence, or of slow atrophic nephritis which has no manifest and single cause. To this pathological group there should be added at least a portion of those cases of albuminuria of puberty, physiological albuminuria, intermittent albuminuria of adolescence, and digestive albuminuria—all different, however, from those six which the writer describes. The principal characteristic of the familial variety is its intermittence. Two grades are to be distinguished: functional disturbances or curable ones, or irremediable organic lesions. The intermittent variety probably belongs to the former. It is probable that there are intermediate grades.—*La Settimana Medica*, No. 40, 1899. I know of a certain family in which there is a general tendency to "nervousness," neurotic affections, apoplexy and heart diseases. Amongst the children I have found quite a surprising tendency to intermittent albuminuria, which at times is quite intense. In one case there was an actual parenchymatous nephritis which was quite severe. The child, a girl of ten years, however, seemingly wholly recovered. Her sister developed later, at the age of twenty, a quite pronounced Basedow's disease, with associated albuminuria of decided persistency. The urine contains numerous crystals of oxalate of lime and no epithelial nor granular casts. The urine is about normal in quantity and in sp. gr. "La fonction fait l'organe, la maladie de la fonction fait souvent la maladie de l'organe."—(A. Robin.)

Frank H. Pritchard, M.D.

POISONING BY POTATOES CONTAINING AN EXCESSIVE QUANTITY OF SOLANIN.—Dr. E. Pfuhl reports an interesting observation where fifty-six soldiers in garrison were seized with symptoms which, seemingly toxic, pointed to a common cause. They consisted in initial chills or shivering, fever of 38–39.5°, headache, violent pains in the abdomen, diarrhœa and prostration. In some cases there was vomiting, in others only nausea; several fainted, and in one there was fainting with convulsions. The majority

of the patients were somnolent and apathic. In seven, in the further course, there was distinct icteric coloration of the conjunctiva, and in one icterus was noticeable on the skin. There was no slowing of the pulse. In one there was a labial herpes, in another salivation. A large number complained of a scratching sensation in the throat. The tongue was but little coated, the fauces somewhat reddened in some cases; in others there was slight catarrh of the respiratory tract. The voice was unaffected. No dilation of the pupils. (Prof. Schulz states solanin will *not* act on the pupil, while solanidin causes distinct mydriasis.) In most of the cases the fever continued even during the third day, and presented a morning fall and an evening rise; but in general it rapidly fell to normal. Nearly all were afebrile on the fourth day. The number of evacuations of the bowels varied between four and six; they were brownish-yellow, thin, and some of them mixed with hard fecal lumps. The potatoes themselves were well digested. In the urine were transitory traces of albumin; no sugar nor bile-pigments. The symptoms in all were more or less the same. From examination of the potatoes it developed that every one who had eaten his full ration of potatoes must have ingested 0.30 solanin, a quantity sufficient to bring about serious toxic symptoms. This was about six times the normal quantity of the alkaloid usually present in potatoes. This vegetable is said to develop the alkaloid during sprouting and during the shrinking process caused by sprouting. All the cases recovered. —*Deutsche Medicinische Wochenschrift*, No. 46, 1899.

Frank H. Pritchard, M.D.

COCAINE IN SENSATION OF A FOREIGN BODY UNDER THE SKIN.—Dr. R. T. Cooper directs attention to one symptom: feeling as of foreign bodies under the skin. This symptom is often met with in cocaine poisoning (Maggan's sign). In a patient who was suffering from this symptom, not of cocaine origin, the administration of the second decimal acted very promptly and effectually.—*Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Hft. iv., 1899. Erlenmeyer calls attention to this peculiar symptom or sign; patients will assert that they have a piece of glass under the skin and search for it with a needle.

ILEUS DURING PREGNANCY AND CHILDBIRTH.—Dr. Leopold Meyer communicates two cases of ileus complicating labor where laparotomy was done. The first, where the obstruction was due to an incarceration of the small intestine in an abnormal opening of the broad ligament on the right side of the uterus, ended favorably. The patient gave birth spontaneously to her child a few hours after the operation and was discharged as cured four weeks later. In the second, where the ileus was from an incarceration of the colon, from a congenital malformation of the mesentery, a forceps operation was done, and as she still continued to grow worse, laparotomy was done and a preternatural anus was formed, as it was impossible to loosen the incarceration. She died three hours after. He also reports a third case, from the Copenhagen Maternity Hospital, where the patient recovered after the use of the forceps. Here, probably, the obstruction was only fecal.

This complication is extremely rare, for in the Maternity at Copenhagen, during forty-two years, only 2 cases out of 56,000 confinements have been observed. In all the cases where no laparotomy was done the patients died.

In four this operation was done and three patients were saved, and from the literature he has collected thirteen cases. In all cases where laparotomy was not done the patients died; in four this operation was done and three were saved, and the patient that died was moribund when she came to operation. In not a single case has emptying of the uterus brought about an amelioration, and hence he thinks that as soon as the symptoms appear one should operate, and during pregnancy or labor one should operate at once, and if the voluminous uterus bother one, a preternatural anus should then be made for the time. Incarcerated hernia is also extremely rare during labor, for he has only found three cases mentioned in the literature, and the indications for the treatment are the same, both during pregnancy and labor.—*Norsk Magazin for Lægevidenskaben*, No. 8, 1899. In the Spanish translation of Auvar's work (*Tratado Practico de Partos*, 1891, p. 491) he mentions the increased inclination to the formation of umbilical hernias while, on the contrary, there is a tendency to the spontaneous reduction of inguinal and crural hernias. All hernias should be sustained during pregnancy and labor, and especially during the efforts at expulsion of the child, when labor should be shortened as much as possible by chloroform, forceps, or manual extraction. In case of strangulation, the same conduct is indicated as outside of pregnancy.

Frank H. Pritchard, M.D.

CHRONIC URTICARIA OF THE MUCOUS MEMBRANE OF THE PHARYNX.—Dr. Merx observed a patient who for several months had at times suffered from sore throat, difficult deglutition and heartburn, which would soon disappear. Objectively at such times there would be profuse salivation, hyperæmia of the uvula and faucial mucous membrane, œdema of the uvula and of one of the tonsils, in short a full picture of an incipient tonsillitis of phlegmonous origin. At the same time there would be violent gastric symptoms. Soon after, a large wheal was noticed on the tip of the tongue, which frequently recurred and gave rise to burning pains. Bromide of potash and locally a 3-4 per cent. solution of nitrate of silver caused it to disappear. The general nutrition remained unaffected. No rise of temperature over 37.4 occurred. Even pressure of the stethoscope was sufficient to cause urticaria (scriptoria) to appear on the skin.—*Muenchener Medicinische Wochenschrift*, No. 36, 1899.

Frank H. Pritchard, M.D.

DIAGNOSIS OF AMYOTROPHY, TYPE OF CHARCOT-MARIE.—Dr. Deguy calls attention to that form of muscular atrophy which was first described by Charcot and Marie in 1886—beginning usually in childhood or adolescence, generally in the small muscles of the hands, though it may first be noted in the feet as painful cramps, formication or emaciation. The disease commences slowly, insidiously, the feet easily taking a false position during walking; the disease progresses slowly for several years, the muscles on the antero-external side of the legs gradually emaciating. Then atrophy is liable to appear in the hand-muscles. Two years' difference marking the interval between involvement of the hands after the feet become affected, the thenar and hypothenar eminences, or the short muscles of the thumb, begin to show atrophy. Thence it extends to the forearm, where it becomes arrested. During this time, in the lower extremities it reaches the lower third of the thigh, where it becomes limited definitely. If now the patient be first seen, one is struck with the well-developed, strong, large and robust trunk, and the contrasting gra-

cility and emaciation of the forearms and legs. The legs are thin, the foot in equino-varus position, the toes *en griffe*; if advanced, the feet are almost dislocated inwardly. In walking, the patient lifts his feet high up or walks like an ataxic, though relatively walking is easy. There is complete absence of tendon-retractions.

In the hands the interosseous spaces are atrophic, as well as the small thumb-muscles and the thenar and hypothenar eminences. The muscles of the root of the limbs are generally unaffected; one should be very careful in diagnosing this type of amyotrophy when such is the case. Motion is impeded; the movements of the metacarpus are less affected than those of the thumb and fingers, while the general aspect is that of the Aran-Duchenne type. In certain cases cyphosis or cypho-scoliosis is associated. *Muscular shocks are a constant feature*, either fibrillary or generalized. The reflexes are variable.

Pain and disturbances of sensibility are not present. There are marked vaso-motor disturbances; local asphyxia; skin violet-spotted, bathed in sweat, sometimes ulcerated. Glossy skin, frost-bite-like appearance, unequal tropho-neuroses, but never any pseudo-hypertrophy. No disturbance of the sphincters nor of the mind. Death is never the immediate consequence, but it occurs from some intercurrent disease. Anatomico-pathologically, the lesion is spinal, affecting the posterior columns, particularly those of Burdach, the cells of the anterior horns, and the spinal ganglia. There is no proper lesion of the peripheral nerves, though in some cases they have been noted as slightly altered. The prognosis as to life is good; as to function, unfavorable. Therapeutically, but little or nothing can be done.—*Journal des Praticiens*, No. 47, 1899.

Frank H. Pritchard, M.D.

THE DIFFERENTIAL DIAGNOSIS OF THE CHARCOT-MARIE FORM OF AMYOTROPHY.—Dr. Deguy, continuing, presents the differential diagnosis very extensively. *Infantile cerebral paralysis* is in general unilateral, the reflexes exaggerated, while there is a very marked spasmodic state and atrophy is very slight in the beginning. *Infantile spinal paralysis* begins either in a few hours, or even days, often after a febrile seizure, and it has more a tendency to retrogress than to continue to invade farther; it is never hereditary and nearly never familial, rarely symmetrical, and the muscles offer the reaction of degeneration to an extreme degree. *Chronic anterior poliomyelitis* begins in the hands, gains the proximal portions of the extremities, rarely commencing in the legs and often in the part nearest the trunk. *Amyotrophic, lateral sclerosis* commences in the upper extremities, the paralysis is always spasmodic, and the disease ends with bulbar disturbances. *Syringomyelia* presents special disturbances of sensibility. *Progressive, hypertrophic, interstitial neuritis* of Déjerine and Sottas greatly resembles the Charcot-Marie form of amyotrophy, but it may be differentiated by marked inco-ordination of movement, Romberg's sign, slight choreic movements, myosis nystagmus and hypertrophy of the nerve-trunks, which are directly palpable. *Chronic multiple polyn neuritis* in certain cases may simulate, but they proceed by "spells," set in in a few weeks, retrogress, improve, are not familial, and often some form of poisoning will be found as the cause. *Progressive myopathy* (progressive muscular dystrophy of the Germans) begins most frequently in the muscles of the root of the extremities, extends to the muscles of the trunk, and

is accompanied by lumbar lordosis and pseudo-hypertrophy. There are no fibrillary contractions, nor reaction of degenerescence. *Chronic spinal muscular atrophy in childhood on a familial base*, of Hoffmann, begins in a subacute or chronic manner, insidiously and during the first years of life. Commencing with a decrease of strength, difficulty of movement and weakness of the dorsal muscles, the paralysis becomes general in the upper extremities, and in the muscles of the neck and back of the neck. There is subcutaneous adiposity. The atrophy is an atrophy *en masse*, the reflexes are abolished, fibrillary contractions absent, and there are no disturbances of sensibility. The patients die in one to four years of a pulmonary affection. One must also differentiate congenital club-foot, and that affection described by Bose as "familial muscular atrophy differing from the Charcot-Marie form."—*Journal des Praticiens*, No. 47, 1899. I know of a case of sarcoma of the posterior mediastinum in a man of middle age, where pressure on the roots of the spinal nerves gave rise clinically to a symptom-picture which was diagnosed by an able neurologist in Cleveland as spinal dystrophy. Later the irregular distribution of the neuralgic pains and atrophy, the appearance of enlarged glands in the axilla of the corresponding side, the difference on percussion and auscultation, together with the appearance of a projecting extension of the malignant growth at the root of the neck, enabled the right diagnosis to be made.

Frank H. Pritchard, M.D.

RAYNAUD'S DISEASE IN A CHILD.—Dr. R. Neurath, of Vienna, presented a child of 5 years before the Medical Club of that city, whose mother two years previously had noted that its hands, ears and cheeks, as well as its nose, would become bluish in cold air. Now and then whitish vesicles would appear on the cyanotic hands. At the same time quite severe pains were experienced. The affected surfaces felt cold to the touch. The child was rachitic; the hands bluish-red, backs of both hands as well as fingers quite swollen, and the ears blue and cold. The nervous system and organs of circulation were normal. Nerve trunks never sensitive to pressure. This case shows Raynaud's disease in the second stage. According to Raynaud, local syncope follows vaso-motor paralysis from peripheral irritation. At first the veins, being poorer in contractile tissue, relax, whence venous stasis results. If the cellular elements be of low vitality symmetric gangrene may result. Cases of Raynaud's disease in childhood are not so very rare. The writer has observed similar symptoms in a child of several months, with associated pulmonary tuberculosis. The prognosis as to life is good, but as to a restoration very doubtful. The appearance of symmetrical gangrene is not improbable.—*Wiener Medizinische Presse*, No. 48, 1899. (An American writer has reported good results in such a case from nitroglycerin.)

Frank H. Pritchard, M.D.

NON-UNION AFTER FRACTURES IN CHILDREN.—Dr. E. Owen, at the Sixty-Seventh Meeting of the British Medical Association in Portsmouth, read a paper on "Pseudo-Arthroses in Childhood." Experience teaches that after fractures of the tibia and fibula non-union may at times occur, and that in such cases even an operation is without result, and amputation may have to be done. Pseudo-arthroses are, on the contrary, more frequent in adults than in children. In fractures of the leg in children a local hindrance is as a rule not observed. There is abundant callus which is fibrous, but ossification does not

occur. The cause of the lacking bone-formation possibly may be insufficient rest. In small children the fracture of the leg may be overlooked. They are carried about with their legs hanging down, and the broken ends are dislocated by the pendant foot. Resection and suture will not bring about healing in fractures of the lower extremity of the leg below the knee; amputation must be done. The abnormal softness of the bones does not account for the non-union. In old cases atrophy of the lower tibial fragment is noted. Possibly there are trophic influences at work; an inhibition from the cells of the anterior horns of the affected side.—*Wiener Medizinische Presse*, No. 38, 1899.

Frank H. Pritchard, M.D.

NITROUS OXIDE AND ETHER ANÆSTHESIA BY THE OPEN METHOD.—Miller (Providence) prefers the use of an open cone for the administration of ether in this method in place of the usual Ormsby inhaler, or some of its modifications, claiming the following advantages:

1. Increased safety. Cyanosis and danger of asphyxiation are done away with, and the patient constantly breathes fresh air.

2. Continuous etherization. As the cone does not need to be removed for this purpose, ether can be administered often and in small quantities.

3. The cleanliness, simplicity and lack of expense of the ether-inhaler.

The amount of ether consumed is greater than by the closed method; less than in simple etherization.

The method of administration is as follows: Nitrous oxide gas is given from the ordinary cylinder, using an S. S. White inhaler and bag. When the full effect is reached the face-piece is removed and rapidly replaced by the ether-cone, which has previously had a quantity of ether poured into it.

The author uses a cone made of a towel and newspaper, open at both ends; into the smaller upper opening he places a wad of absorbent cotton. We would say, the well-known Allis inhaler would be more serviceable and better suited to the requirements of an "open" method.

In all, one hundred and sixty cases are reported. Of these, not one was conscious when the change was made from gas to ether. The average time required for anæsthesia was 3.05 minutes, the shortest time for an adult was fifty seconds.

There is much less nausea and vomiting than is usually present where ether alone is administered. The records show 46 per cent. of the patients experienced nothing unpleasant in anæsthesia or recovery; 84 per cent. did not vomit at all; 11 per cent. vomited slightly, and 5 per cent. vomited considerably.—*Annals of Surgery*, December, 1899.

Gustave A. Van Lennep, M.D.

WHITE GANGRENE.—Under this heading Hopkins (Brooklyn) takes up the consideration of those injuries occurring from the use of the X-rays, commonly known as "Burns." He objects to the use of this term, pointing out, first, that the injury is not produced by heat, and secondly, it does not possess any of the characteristics of a burn. The term "white gangrene" is applied, for the reason that a theory can be formed as to the cause of a gangrene, which is rational and meets all the conditions of the destruction wrought in the tissues. It is as follows: "The destruction of the nerve supply of the affected tissue by that factor, electrically produced, which is known as the X ray."

According to the author's conclusions, this destruction is brought about by the passage through the nerves of an X-ray current of greater intensity than they are able to carry, just as a copper wire may be destroyed by forcing into it a greater current than it is able to transmit. This is the latest explanation of this most interesting phenomenon, some of the others being:

1. Tesla's theory—that the injuries caused by the ray are due to the effect of ozone elaborated within the tissues.

2. Gilchrist's theory—that particles of platinum are carried by the cathode-ray through the glass of the bulb in fine particles, through the air, through the skin and into the deeper tissues of the body, after a time to set up destructive action.

3. Elihu Thompson's suggestion that the injuries are caused by the X-ray or something that accompanies them.

4. Leonard's theory—that the X-ray burn is the result of an interference with the nutrition of the cells, produced by the static electric changes or currents, which are induced by the introduction of the patient's tissues into the high potential induction-field surrounding the tube.

The author points out the fact that lesions of the skin and deeper tissues are produced more frequently by tubes that are energized by alternating currents than by those energized in any other way. He recommends, therefore, the use of the static machine, and preferably one that is worked by hand. Other precautions to be taken are: A not too long exposure, and guarding against too small a distance between the tube and the object being skia-graphed.—*The Philadelphia Medical Journal*, January, 1900.

Gustave A. Van Lennep, M.D.

DIFFERENTIATION OF THE URINES.—Brown (New York) presents a new instrument for the catheterization of the ureters. It is a modified Brenner ureter cystoscope, having for its special feature a double, instead of a single catheter attachment.

It serves the following purposes:

1. In favorable cases to catheterize both ureters at approximately the same time.

2. In less favorable cases, after passing one catheter, to use the second channel for drawing the distending fluid from the bladder, thus giving the organ repose.

3. In still more difficult cases to use the second barrel for frequent irrigations, until fluid of proper transparency distends the bladder and permits localization of the ureter, when a catheter, which has been reposing in the other barrel, can be made to engage the ureter. By taking hasty advantage of a momentarily clear fluid success may be made of an otherwise failure.

4. In some of the impossible cases, or where for various reasons but one ureter can be catheterized, this double-barrel instrument would in the latter case permit access to one ureter through one canal, and urine coming into the bladder from the opposite kidney could be collected from that source by catheter siphonage through the second barrel.

Both barrels could be utilized for this sort of indirect urinary collection through parallel catheters, providing the intervening vesical ridge were lifted from within the vagina or rectum, as in Dr. Harris's device, the visual properties of the cystoscope being first utilized to ascertain the condition of

the bladder. The instrument is but one and a half millimeters greater circumference than Brenner's.—*Annals of Surgery*, December, 1899.

Gustave A. Van Lennep, M.D.

SALT SOLUTION IN ECLAMPSIA.—(Allen.)—Do not stimulate the uterus to contract after delivery, but let the patient bleed, and if the bleeding is insufficient open a vein. Introduce as soon as possible after delivery 700 c.c. of salt solution under each breast. Promote elimination by bowels, kidneys and skin. Two drops of croton oil, in two teaspoonfuls of olive oil to diminish the irritating effects, are recommended, followed, if necessary, by a teaspoonful of Epsom salts every hour, and an enema. Give half an ounce of an infusion of digitalis every four hours if the kidneys act badly, and also use the hot-air bath or wet pack. It is impossible to realize the great advantages of the salt solution without having used it and watched the results.—*American Journal of Obstetrics*, May, 1899.

George R. Southwick, M.D.

THE DIAGNOSIS OF TUBERCULAR PERITONITIS.—(Gallant.)—1. Tubercular inflammation of the peritonæum is met with at all ages, and is most common in early and adult life.

2. It is most frequently met with in women, and between the ages of 20 and 40 years.

3. It most often originates in the pelvic sexual organs, and from that point may extend to the visceral and parietal abdominal peritonæum.

4. As a primary lesion of the peritonæum, it resembles in its inception, subsequent history and final outcome, the various forms of the disease in other serous cavities. It may be secondary to tuberculous disease in any other part of the body, especially the lungs and pleura.

5. The most distinctive features of this disease are: (a) a rather constant subnormal morning temperature, rising to the normal in the late afternoon, reaching a little above at night; (b) hypogastric pain on pressure, on walking, and when urinating; and (c) the presence of tubercle bacilli in the pulmonary, cervical or vaginal secretions.

6. Anæsthetic examination in pelvic cases will often aid in clearing up the diagnosis, but when the abdomen is tensely distended with ascitic fluid, unless immediately preceding operation, it will only subject the patient to useless discomfort.

7. A positive diagnosis, other than by exploratory incision, is in some cases impossible.

8. Early abdominal section, evacuation of the fluid, removal of the original focus, carefully avoiding any attempt to break up intestinal adhesions, thorough irrigation of the cavity with saline solution, and closure of the abdomen without drainage of any form, has been shown by later operations for other conditions, and on autopsy, to have resulted in permanent cure.

9. When confined to the pelvis, removal of the original focus usually results in a permanent cure of the disease.

10. Where fluid reaccumulates a second celiotomy will be curative or prolong life.

11. Tubercular disease in other parts, especially the lungs and pleura, is not a contraindication to operation, which will be followed by a more or less prolonged abeyance or retardation of the disease.—*American Journal of Obstetrics*, October, 1899.

George R. Southwick, M.D.

THE USE AND ABUSE OF NORMAL SALT SOLUTION.—(Boveé.)—It has been used in puerperal sepsis with fair success, either in small quantities, subcutaneously, frequently repeated, or by large intravenous infusions. Brilliant success has attended its use in puerperal eclampsia combined with blood-letting. J. Whitridge Williams removes nearly a pint of blood, and injects subcutaneously double the amount of normal salt solution, repeating the latter daily until the urine is normal.

The principal uses of normal salt solution are for shock, hæmorrhage, and sepsis. Its greatest influence in shock is exercised if employed early. If shock be from operation, infusion should be practiced on the table in grave cases and immediately after operation in mild cases. Here the subcutaneous method is best, but the rectal way is especially valuable, one or two litres being easily thrown in the bowel, especially in the Trendelenburg position, and, if the temperature be from 115° to 120° F., exerts a powerful influence in the reduction of shock. The same plan of treatment is followed for hæmorrhage. Severe hæmorrhage is about the only indication for intravenous infusion. The writer advises in abdominal operations to leave a considerable quantity, one to fifteen litres, in the abdominal cavity. It is particularly good to promote urinary excretion and to reduce shock. It floats intestine from denuded surfaces, prevents adhesions, and dissolves exudates which otherwise might produce agglutination. It dilutes foci of infection and promotes absorption. It prevents the formation of coagula from venous oozing and diminishes the thirst after operation. Large quantities of intravenous transfusion are contraindicated by myocarditis, pericardial effusion, atheroma, arterio-sclerosis, cardiac degeneration, bad valvular lesions, thromboses and recent cerebral apoplexias; chronic inflammatory conditions of the kidneys, sclerotic and tubercular, are apt to be aggravated by it. Chronic affections of the liver and lungs are made worse, especially if a malignant character. The intravenous method should not be used for active hæmorrhage before ligation of the blood-vessels. Chills following shortly after injections of salt water are harmful, notwithstanding their easy correction by morphia hypodermatically. Pneumonia has been known to follow too rapid inflow of the solution in intravenous injection. The tension of the arteries is the criterion as to the amount of the solution to be employed, sepsis excepted. —*American Journal of Obstetrics.*

George R. Southwick, M.D.

SUSPENSIO-UTERI.—(Norris.)—After a very considerable experience with the various methods of treating retroversions of the uterus, he advocates that known as suspension of the uterus. It is an operation almost always followed by good results, and has the least danger of any abdominal operation. The surgeon undertakes it with the greatest confidence, and it entails no danger, practically, to life in the hands of a skillful man. He thinks there is no operation on the pelvic organs which gives such brilliant results. The incision should be short, and all the adhesions of the uterus separated. An ordinary tenaculum is useful to steady the uterus. A short, half-curved, spear-pointed needle, without cutting-edges, is to be preferred. The stitches should be half an inch apart, and be buried half an inch in the tissue of the uterus. The first stitch should catch a few fibres of the posterior surface of the rectus muscle, to prevent the formation of a dead space between the peritonæum and the

under surface of the muscle ; the second stitch takes only the parietal peritonæum. The first stitch should enter the uterus a line or two posterior to the level of the uterine cornua. The abdominal wound is closed with through-and-through silk-gut stitches, with a running catgut stitch in the fascia of the rectus muscle.—*The American Gynecological and Obstetrical Journal*, May, 1899.

George R. Southwick, M.D.

EPILEPTIC EYE-STRAIN.—This term the writer considers well applicable to those cases where eye-strain is supposed to be the cause of epileptic seizures. It seems a very logical conclusion that eye-strain might produce an epileptic convulsion.

When we consider the complicated arrangement of the nerves of the iris and ciliary processes, I do not believe that the direct effort that is made by the eye to produce normal refraction causes an epileptic attack ; but the continued effort that is put on the filaments of the nerves of accommodation in course of time sets up a reflex condition of the sympathetic system that produces the paroxysm, just as it does in other organs of the body. The writer reports the following two cases of epileptic eye-strain :

Case 1.—Miss Z., aged 9 years, came under observation one year ago with this history : Epileptic convulsions since 4 years of age ; from three to six every month. Pupils dilated with atropine and convulsions stopped. A compound myopic astigmatism was corrected with lenses. There has been no return of the epilepsy at the time of the present writing.

Case 2.—A girl, 8 years of age, had frequent epileptic attacks since three years of age ; the correction of a compound hyperopic astigmatism caused a complete cessation of the attacks for the past five months. "It is fair to say that the good results of belladonna in these cases was due only to the power it had to dilate the pupil (and paralyze the accommodation), and it was lost as soon as the effect passed off."—C. M. Capps, *N. Y. Med. Jour.*

Wm. Spencer, M.D.

A NEW CASE OF PURULENT OPTHALMIA IN AN ADULT cured by the employment of a concentrated solution of permanganate of potash. Viau's method of treatment consisted in the cauterization of the conjunctiva of the eyelids with a 10 per cent. strength solution of permanganate of potash, and to employ cataplasms, changed every two hours, in association with hot lotions of boric acid. In less than nine days' time the discharge from the right eye had ceased, though a small corneal ulcer had formed. The cauterizations were discontinued, and antiphlogistic treatment was applied with success. In the left eye this disease was checked within three days' time after the institution of the treatment.—Viau, Toulon, *Recueil d' Ophthalmologie*.

Wm. Spencer, M.D.

BILATERAL IRITIS OF MALARIAL ORIGIN.—A case of double iritis with the exacerbations following malarial attacks is reported by Pechin. The right eye was affected after an attack of intermittent fever, and five or six years later the left eye suffered a similar disturbance. The interesting part of the case is that the other portions of the eyes had apparently escaped.

For explanation the author offers the fact that while the capillaries may be filled with the plasmodia the larger vessels may be free from them.—*Recueil d' Ophthalmologie*.

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

ON THE PATHOGENESIS OF BORIC ACID.—Dr. J. Evans in treating a patient with cystitis prescribed from ten to eighteen grs. of boric acid daily internally. After three weeks the patient became affected with an erythema, beginning at the neck, extending onto the face, and soon involving the entire head. All the affected parts presented subcutaneous oedema and dermatitis, with formation of fine scales. There was simultaneously a swelling of the salivary glands. The hair from the scalp and the rest of the body fell off so rapidly that in fifteen days the patient was wholly bald. On leaving off the remedy complete recovery followed. The writer has noted the same symptoms in other patients taking boric acid. He has also noted onychia and splitting of the nails. (Kobert—*Lehrbuch der Intoxikationen*, p. 300—citing different writers on the innocuousness of boric acid internally, doubts this very much himself. Forster and Schlenker have demonstrated by extensive and very reliable investigations on man that from daily ingestion of 3 grs. of boric acid the absorbing powers of the digestive intestinal tract are lowered, and a desquamation of epithelium and secretion of a great deal of mucus is brought about.) These points will be of service in treating affections of the hair and nails.—*Journal Belge d'Homœopathie*, No. 4, Vol. vi.

Frank H. Pritchard, M.D.

ARSENIC AND MELANODERMIA.—Drs. Enriquez and Lereboullet in the wards of Brissaud, in Paris, have noted in a patient who had taken Fowler's solution for a year, that he presented a generalized brownish discoloration of the skin, which absolutely simulated Addison's disease. The absence of the characteristic asthenia and the somewhat speckled appearance of the coloration served to exclude this disease, and led to a diagnosis of poisoning by arsenic. And, indeed, after leaving off the drug there was a marked improvement, which rendered it quite probable that this was the cause. Other cases have been published and similar, notably by Mathieu.—*Ibidem*.

Frank H. Pritchard, M.D.

ACTION OF KALI BICHROMICUM ON THE ORGANS OF DIGESTION.—Dr. Th. Ord states that the profound action which kali bichromicum has on the digestive tract and the similar grave states which it cures are undoubtedly caused by a specific elective influence, for, except the ulcers of the mouth and œsophagus, the action is the same whether it be given by the mouth, hypodermatically or intramuscularly. The mucous membranes present every grade of inflammatory change, from simple catarrh to the most extensive and perforating ulcerations. Thus we have catarrhal inflammatory affections of the throat, which become ulcerative, with tonsillitis and an associated exu-

date, which resembles that of diphtheria; or there are "punched out" ulcers on the tonsils, with caseous exudation. In these cases, clinically, kali bichromicum has shown great curative power. In the stomach its first effect is an irritative gastritis, with salivation and vomiting of a watery, sour fluid; this latter soon becomes bilious and yellow. If the influence of the drug become more intense, great quantities of thick and tough mucus are secreted and vomited. The tongue is then thickly coated, yellow or white, especially on the posterior portion. In the first irritative stages a specific action on the mucous membrane of the tongue is noticeable. In one case there was a narrow brown stripe from the tip to the base of the tongue, which increased as the remedy was continued, with a sensation as of a thread on the posterior portion of the tongue. This disappeared as soon as the drug was discontinued, and reappeared as soon as it was taken again. The curative action of this remedy in these states, with functional disturbances and serious lesions of the stomach and duodenum, particularly ulcers, has been demonstrated by authorities of both schools. In ulcer of the duodenum there is a striking similarity between that produced by this drug and the ulcer that follows extensive burns. Congestion of the liver, with periodic attacks of bilious vomiting, have both been caused and cured by kali bichromicum, but they are not associated with discharges of bile per rectum, but bilious vomiting and slimy passages. In the liver fatty degeneration, similar to that of ars. and phos., has been observed, yet clinical evidence of its value here is wanting as yet.

In the intestines all lesions from simple catarrh, with sensitiveness of the abdomen to cold, to acute enteritis, with violent pain and bloody, slimy stools, have been produced and cured. Dysentery, especially the chronic form, which is worse mornings after rising, often with insufficient control of the sphincter ani, have been caused and cured by this remedy.—*Zeitschrift des Berliner Vereines Homœopathischer Ärzte*, Hft. ii., Bd. xviii.

Frank H. Pritchard, M.D.

MERCURIUS SULPHURICUS IN PLEURAL EFFUSIONS.—Dr. R. Haehl reports the case of a middle-aged man who, pale and with slight evening rise of temperature, presented a pleural effusion, filling the whole left cavity. Iodum 3x and bryonia 6x were given, without success. After having taken mercurius sulphuricus for eight days the effusion had decreased one-half. Later sulphur was to be administered.—*Homœopathische Monatsblätter*, No. 11, 1899. (In the homœopathic pharmacopœias there are this remedy, the sulphide, as well as the sulphate, cinnabar, and a black sulphuret, *æthiops mineralis*.)

Frank H. Pritchard, M.D.

KALI BICHROMICUM IN DISEASES OF THE RESPIRATORY TRACT.—Dr. Th. Ord finds this drug to have a specific action on the organs of respiration, which has been demonstrated by provings on men and animals, as well as observations made on workmen at chrome works. Nasal catarrh, with secretion of thick and tenacious mucus or yellow scabs, has frequently yielded to kali bichromicum. Many cases of tuberculous and syphilitic ulcers of the septum have been cured by it. In the larynx, trachea and bronchi the initial stage of action resembles the first stage of bronchitis and laryngitis, a dry inflamed mucous membrane, with burning, distress on breathing and a tickling cough. This is soon followed by swelling of the mucous membrane, and secretion of

the well-known fibrinous and tenacious mucus, which, when the action is intensified, becomes muco-purulent, and an acute bronchitis becomes a chronic catarrh. In both cases kali bichromicum has been a very useful remedy. In some cases the exudate is membranous, with whitish threads, which follow the finer bronchi. The similarity to the false membranes of croup, and even true diphtheria, is very pronounced. In some cases of diphtheria, if well selected, it has undoubtedly been of signal service. Here it resembles merc. bin. and merc. cyanatus, though the bichromate has a greater tendency to invade the larynx. When the characteristic stringy mucus is secreted the remedy is often indicated.—*Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Hft. ii., Bd. xviii.

Frank H. Pritchard, M.D.

TREATMENT OF SCIATICA.—In the French journal *L'Art Medical*, No. 8, 1899, the therapeutics of sciatica are presented thus:

Aconitum.—In sciatica following exposure to cold, or where the seizure has been preceded by chills and fever, or the pains are acute, lancinating or benumbing. This is a type of congestive neuralgia, the pains being usually worse nights and aggravated by movement—(G. Bonino), *Primi Studi di Materia Medica*, 1893, p. 58—"drawing pains in the thighs extending down to the knees." Sense of torpor, coldness and formication in the lower extremities as though paralyzed.

Belladonna.—Great sensitiveness along the course of the sciatic nerve; the least touch, even the contact of the clothing, causes intense pain; the position must frequently be changed, the pains being worse nights; the patient tries to sleep but cannot; amelioration from heat and by the limb sweating.

Bryonia.—Aggravation from the least movement; relief from lying on the affected side, the pains being acute and piercing. In cases of long duration there is atrophy of the limb.

Colocynthis.—Acute lancinating pains, with shooting pains in the sacral region, extending into the hip, thence into the knee, and from the knee to the heel. They are worse nights; the pain is constant, with acute paroxysms, the limb seeming to be benumbed. The pain is also worse from cold and motion, ameliorated by warmth and rest. Here it resembles bryonia. (In one case where it cured there was an inclination to bend over and double-up with the pain, in order to find relief.)

Ferrum.—Violent pains at night force the patient out of bed and to walk about; though he can scarcely put his foot to the floor, yet he feels relieved in walking about. The legs are stiff and heavy, the feet swollen, there is general anæmia and emaciation, loss of appetite and great weakness. (Ferrum is a valuable remedy in some cases. It will succeed when others fail. I once observed a case where, after an allopathic physician failed to relieve, the patient cured himself by pouring two papers of carpet tacks into a jug of hard cider. He then drank the cider by the glass three times a day until he was cured, which was not long. A domestic remedy in Sweden is milk boiled with nails. In northern Ohio, a pint of Catawba wine is poured over a handful of shingle nails, and they are permitted to macerate for several days. The resulting iron preparation, probably a combination of the acetate and tartrate, is then drunk as a remedy in sciatica and anæmia.)

Iodium.—Pain which shoots from the foot into the upper portion of the limb with a sensation of muscular contraction; the limb is very much colder than the rest of the body. The soles of the feet are very sensitive.

Magnesia Phosphorica.—Impossible to remain in bed at night ; he must be up the whole time ; the pain comes in violent, lightning-like attacks. There are two other remedies : *rhus tox.* and *arsenic*, which should not be omitted. The action of *ars.* and *cuprum arsenicosum* on the sciatic nerves is characteristically elective. Sieffert recommends high dilutions, yet I have cured cases with the second decimal, one gr. *ter die*. Puhlmann—*Handbuch der Homöopathischen Praxis*, p. 479—recommends it in cases where the pains appear typically at night (*chinin. arsen.*). He advises the fifth dec. dil. Towards midnight the pains become almost unbearable, there is great restlessness, from the burning, tearing pains which oblige the patient to move the limb often in order to get relief, but the pains are increased by vigorous motion. *Rhus* has also a certain degree of restlessness, while the pain at first is aggravated, with subsequent relief, then later to become worse again.

Frank H. Pritchard, M.D.

TREATMENT OF NEURASTHENIA.—Dr. Donner, in a recent paper on neurasthenia and its treatment, placed great weight on the value of *arg. nitricum*. Thence may be placed successively, in the order of their importance, *platina* where the disease is due to excessive work ; especially in women and hysterics. *Phosphor. acid* and *ignatia* are also often indicated, the latter in women. *Nux vom.* and *natr. mur.* are especially of value in the digestive disturbances of neurasthenics. The latter is also useful in a number of other nervous diseases. As neurasthenia is nearly always combined with *anæmia* and *chlorosis*, the iron compounds are best associated, naturally, in homœopathic form ; for example, *ferrum phos.*, *ferrum citricum*, *ferrum oxydulatum rubrum*.—*Rivista Omiopatica*, No. 2, Anno xlv.

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TREATMENT OF WHOOPING COUGH.—Dr. Cartier thinks that though *drosera* is the remedy most often used in *pertussis*, yet it is not the typical one ; rather would he regard *corallium rubrum* as such (*Teste*). He follows with *chelidonium* to complete the cure, though not until the attacks have ceased, for if used too soon it will aggravate. *Drosera* and *corall.* may be alternated. *Passiflora incarnata* has served him better than *bell.*, *con.*, *hyos.*, etc., which have nightly aggravations in those cases where the attacks are worse of nights. Two drops are taken after each attack of coughing, yet not more than six to twelve during any one night.

Cuprum in violent, spasmodic coughing, where the child becomes cyanotic and the lips violet, with muscular twitchings, is of value.

Ambra grisea in *pertussis* with eructations. In a case with this symptom, where no remedy appeared to help, *ambra grisea* 3x in twenty days cured the child. *Coccus cacti* is indicated where the child wakes up with a violent attack of coughing. Frequently the child will have two coughing seizures, one after the other, where *merc. corr.* will be indicated. The third stage, with its nervous cough, requires generally *hyos.* and *puls.* Here a change of air does good.—*Homœopatisk Tidsskrift*, No. 10, 1899. Osler states whooping cough to be one of the most deadly diseases in childhood ; not from its immediate effects, but rather from its tendency to waken any latent tuberculous deposits in the lungs. I have found it a disease to be respected and carefully watched.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

MARCH, 1900.

GELSEMIUM SEMPERVIRENS, AIT.

BY M. W. VAN DENBURG, M.D., MOUNT VERNON, N. Y.

(Read before Westchester County Medical Society, Jan. 31, 1900.)

THIS is not intended to be an exhaustive paper on this well-known remedy, either from a historical, pathological or therapeutic standpoint.

The aim is to call attention to some of the more important things that a practical man wants to know, and to illustrate the views of the two schools.

First, there are two names for this drug: g-e-l-s-ē-m-i-u-m and g-ê-l-s-e-m-i-n-u-m. The first is the one most usually accepted and used in the United States. The other, I have been told, is in common use in Great Britain, and is said to be derived from the Italian gelsomino.

Gelsē'mium sempervirens, or yellow jasmine, grows commonly in low ground, from Virginia southward, climbing by its twining stem to considerable height in trees and over bushes. It is also cultivated as an ornamental shrub. As its name indicates, it is perennial, and in the far South evergreen, with beautiful shining leaves, and many small, showy yellow flowers, from an inch to an inch and a half long, in the axils of the opposite leaves. The bark of the root is the part used in medicine.

This plant belongs in the same large group (Loganiaceæ) as spigelia.

Our allopathic and eclectic friends use the drug to some extent.

Bartholow ("Materia Medica and Therapeutics," 1890) says:

"*In moderate doses*, gelsemium causes a feeling of languor and mental calm, slowing of the heart and drooping the eyelids; *in larger doses*, great muscular weakness, paralysis of the levators of the lids, double vision, vertigo, slow and feeble heart-action, and labored respiration, in consequence of a paretic state of the respiratory muscles, while sensibility to pain and touch are much reduced.

"*In lethal doses*, the respirations are labored, shallow and irregular; the heart weak, feeble and intermittent; the skin usually covered with profuse perspiration, but there are no evacuations. It is impossible to open the eyes; vision is lost; the pupils are widely dilated, and cease to respond to light. The jaw drops, the tongue is paralyzed. Death occurs from asphyxia, and the action of the heart continues after respiration ceases. Unconsciousness comes on from imperfect aëration of the blood, and convulsions never occur." (P. 615-616.)

Dr. Hare ("Practical Therapeutics," 1895) says: "Gelsemium paralyzes the spinal cord, particularly on its sensory side, although the motor side is certainly ultimately depressed. Death in toxic cases is caused by centric respiratory failure, and is almost simultaneous cardiac arrest." (P. 194.)

Dr. Potter ("Hand-book Materia Medica and Therapeutics," 1897) says: "Gelsemium is a powerful depressant from central action on the spinal cord." He gives the same objective symptoms as Bartholow—the staggering gait, labored respiration, ptosis, slow and feeble heart-action, and a decided lowering of bodily temperature.

Of course our friends have learned very little from the toxic action of the drug for its application in disease.

Bartholow says: "It is indicated in those maladies in which an exaltation of function has taken place in the motor and sensory spheres. In inflammatory states of the meninges of the brain and spinal cord. (P. 617.) In neuralgia of the fifth pair, and in intercostal and sciatic neuralgias; convulsive and spasmodic coughs; in acute inflammations of the lungs and pleura; in pelvic disorders of women; in some cases of remittent and typho-malarial fevers; in pruritus and eczema." But his indica-

tions for its use are extremely vague and unsatisfactory. In all cases he recommends that it be given "until its characteristic effects begin to appear." (P. 618.)

Potter says: "It is indicated in all conditions of exalted nerve-function, and contra-indicated wherever there is a weak heart." His list of diseases is in all points similar to Bartholow. He further says: "It is not suitable to *low fevers*, and has not sufficient power as a depressant to be of much use in sthenic forms." (P. 290.)

Hare, as usual, doubts everything anyone else recommends, and has no suggestions of any value himself.

This book, one of the latest products of allopathic therapeutics, is about as barren in positive help to the physician as any book of seven hundred pages could well be. It is pessimistic, derogatory and dubious from cover to cover, and may well stand for an effete system in its last stages. He says nothing good that has not been said much better by others; while the uncertainty of most of his indications might well be classed along with those of an "Indian doctor."

From this let us now turn to the homœopathic materia medica and therapeutic use of the drug. Allen gives thirty-four provers and sources for the symptoms he records.

Unfortunately there is not enough history given in each or any of these cases to draw an intelligent conclusion as to the circumstances of administration. And this is a grievous omission, if one goes to Allen for an intelligent insight into the provings.

Still he professes to give only *pure symptoms*, or drug effects, and no "cured symptoms."

Hering gives Allen as authority, and adds a long list of references to *cured cases and symptoms*, covering a wide range of homœopathic literature and publications. He says the drug was introduced by Dr. Henry in 1852.

As far as the symptoms are concerned, perhaps no drug has been more frequently and thoroughly studied by homœopathic physicians with a view of reforming the symptom-list. The Boston Materia Medica Club, the Baltimore Materia Medica Club, and, if I mistake not, a medical club in Philadelphia, have each presented us with revised lists. The Boston Club proposed to admit only those symptoms that have appeared in

at least *two* provers. The Baltimore Club took practically the same ground, and in addition, condensed many similar expressions. The result was a symptom-list that might have stood for any one of several drugs, so general did it become.

I propose in the remainder of this paper to give, for the most part, only personal experience, and see how it agrees with these methods of improvement of *materia medica*.

I have not used gelsemium in erethric cases as a rule, as is recommended by our allopathic confrères.

In the grippe, I, in common with most others, have found it a potent remedy. But it has its own field here, as everywhere. In those cases marked by profound prostration, slow, full pulse, much pain in the head, especially the forehead; and in the back, especially in the small of the back; and in all the limbs, with desire to close the eyes, to lie down and to be let alone, with great disinclination to muscular exertion of any kind; face dull-red; eyes bloodshot; throat sore and raw; head stuffed, and with or without a watery catarrhal cough; with a feeling that a rod is a mile long, and a quarter of a mile an impossible journey, such cases are always helped by gelsemium.

I usually use the first tenth, about one-fourth drachm to half a glass water; for adults, a teaspoonful every quarter hour until the headache lessens, then every hour until pain is all gone from every part. If the case is taken within two hours of the attack, which is often sudden, a teaspoonful every ten minutes for two to four hours will often abort the case entirely, the patient only feeling depressed for three or four days subsequent to the attack. All this is readily founded on the provings.

I have not used gelsemium in pneumonia nor in pleurisy, so cannot say whether it is useful or not.

A few years ago I noted these symptoms in Hering: "Pharyngeal inflammation, *with pain on swallowing, shooting up into the ear.*" "Catarrhal deafness, *with pain from throat to middle ear.*" "Earache from cold." "Coryza in changeable weather, with inflammation of upper part of throat, *and shooting pains into the ear when swallowing.*" These symptoms are marked in Hering by one heavy stroke, which means, "Symptoms verified by cures." None of these symptoms occurred in provers, hence none are found in Allen, and we must conclude that they are only such symptoms as have been *cured by use of the drug.*

This is the class of symptoms that all our reformer friends have decided to throw out without mercy. And this is the result of giving them a trial, as far as I am concerned. In all cases of catarrhal colds, *with pain streaking to the ear on swallowing*, I have not failed to relieve the case in a single instance. This symptom, which doubtless arises from an inflammation of the Eustachian tube that has extended from the throat to the middle ear, and hence threatens otitis media, has not failed in a single case to be relieved, and the ear trouble aborted.

Again, earache in children, "*with increased pain on swallowing*," has in all cases yielded to this drug.

Besides this, nearly every case of earache has been helped by gelsemium, *if it was neuralgic or catarrhal*; but I am inclined to think that most of the apparently neuralgic cases were catarrhal.

Again, in the beginning, parenchymatous tonsilitis or quinsy is almost always accompanied by pain shooting into the ear on swallowing.

In all such cases, if the remedy was given during the first six to ten hours, the case was aborted completely, no pain or soreness remaining after twelve to twenty-four hours; and I have known cases cured in three hours. But it is rare to get a case early enough for that. In all of these cases I give enough of the 1x, or the tincture in water, to render it distinctly opalescent, and repeat dose, one teaspoonful, very, very often, until the head begins to swim and the eyes blur; then less often until pain is all gone. This in adults.

In children I give 1x or 2x until ease, and generally sleep, is produced.

The use of gelsemium in quinsy is comparable to silicea and to hepar sulphuricum. I have aborted cases with silicea, but much less quickly. A silicea case, I would suppose, might differ in not being so rapid in its onset, and in less feverishness. The hepar case is possibly distinguished by *greater tenderness between periods of swallowing*. But my first reliance is usually on gelsemium. If pus has formed, as is usually the case after twenty-four hours, I begin with gelsemium to reduce the swelling, and follow with hepar or silicea to hasten resolution.

In neuralgia I have not used gelsemium very much. This is true of the various forms of facial neuralgia, because in

mezeureum, spigelia and aconite I have usually found sufficiently good remedies.

In lumbago I have found gelsemium often useful, but not uniformly so. If much prostration is present, it rarely fails. The same is true in cases of inflammation of the sciatic nerve. In meningitis I have always used other drugs. In paralysis from cold, which is in my experience rare, but of which I have seen two cases, I used gelsemium in one, with apparent benefit. In the other I used agaricus, but did not learn the result, as the patient came from a distance. In apoplexy, in a very severe case of paralysis, first on the left, followed in a few hours by paralysis of the right side, entire loss of motion and speech, with only power for some weeks to move eyes and eyelids, and very difficult swallowing, food was given to the patient lying on the side, liquid, and only a little at a time. The bladder and bowels were partially under control after a few days, but not at first; consciousness was never completely lost, but the mind was very hazy and confused: the pulse was slow, large, and intermittent at first, afterwards very rapid and very small.

Intercurrent remedies were used from time to time—aconite, arsenicum, cimicifuga, and some others—but gelsemium was the main drug from the first. The patient, a woman near 60 years, ultimately regained the use of speech, of the upper limbs and of the mind. The lower limbs showed some symptoms of improvement, but she never could step one foot ahead of the other. Ultimately she entirely lost the use of the legs.

She is still living, after four or five years, in good general health, clear-headed and free from pain. She never had neuralgic pain for any length of time during her partial recovery. Once or twice there were intimations of it, but they at once yielded in a few hours to the use of gelsemium, and an occasional dose of the same for a few days after improvement.

I have used gelsemium in other and less severe cases of apoplexy with good results. I would consider it especially indicated in the very painful neuralgias that often follow an apoplectic seizure.

I have used gelsemium in a few cases of malarial fever. There is more or less aching all over; usually it is a well-marked symptom; the chill and fever are generally only moder-

ate, and there is little or no sweat. The most prominent symptom is the utter prostration, with desire to lie still and be let alone, which is out of all proportion to the other symptoms. Such cases seldom fail to be benefited by gelsemium.

One other thing remains to be mentioned in which I have found I could depend on gelsemium. Hering gives, with one heavy stroke before it, "A peculiar action of the heart as if it attempted to beat but failed to do so, the pulse intermitting each time." And, "Fears that *unless she keeps moving* her heart will stop beating, with fear of death." These symptoms, in a patient with valvular insufficiency and cardiac dilatation accompanied by hypertrophy, were usually relieved by gels. 3x to 6x.

A contrary state in the same patient, where it seemed as if her heart would stop beating *if she moved at all*, was always relieved by digitalis 4x to 12x.

In both symptoms there was more or less hysteria, in all probability; but the case is still living, and still subject to these attacks at various times. Its efficiency has been demonstrated in several other cases having the same peculiar sensations, and gelsemium may be depended upon to relieve. The symptoms given are not in Allen's "Cyclopædia." I would be exceedingly glad to learn of other symptoms of gelsemium that have been verified in practice, especially in inflammation of the lungs or pleura, or in cerebro-spinal meningitis.

WOUNDS OF THE ABDOMEN, WITH REPORT OF A CASE.

BY GUSTAVE A. VAN LENNEP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sept., 1899.)

IN looking over the literature of penetrating wounds of the abdomen, I was struck with the dearth of articles pertaining strictly to this subject. A perusal of the "Index Med." for the last five years shows some forty pamphlets, the majority of which appeared in Indian journals that were not accessible. Of the remaining cases, a number were obtained somewhat similar to the one on which this paper is based. It is not my

intention to take up your time with a discourse on the surgery of the gastro-intestinal system, but simply to report the following case, which, on account of its unusual features, may be of some interest to the members of this Society :

L. G., aged 10 years, was brought to the Hahnemann Hospital on July 7th, having fallen through a skylight some twenty minutes before. When seen he was found to be in a condition of extreme shock, with almost continuous efforts at vomiting. On the right side of the abdomen, just inside the anterior superior spine of the ilium, was a wound about two inches in length, through which protruded the greater portion of the small intestines; at each effort to vomit, more coils would be forced out, until the opening had become choked and the extruded portion was partially strangulated. To cap the climax, the protruding mass was wrapped up in a piece of old blanket—the handiest object found by sympathizing friends—plentifully covered with dirt. The muscles of the upper thigh, anterior surface, and the soft tissues over Poupert's ligament, were badly torn, from which there was free hæmorrhage, the wound extending down to and just grazing the femoral vessels. It appeared as if a piece of glass had struck the upper part of the thigh, cut through the skin and muscles in an upward direction, and entered the belly obliquely. No fragments of glass were found in the wound. While hurried preparations were being made for operation, infusion was performed, a quart of normal saline solution being thrown into the left median basilic vein. This brought up the pulse at once, and ether was administered. The opening into the abdomen was so tight it was impossible to introduce the finger, or even to make out the extent of the wound by sight or feel. Accordingly, a straight incision was made along the linea semilunaris, as for an appendectomy, the finger introduced into the belly, brought out at the original wound, and the two cuts united. This gave us plenty of room for manipulation, and freed the gut from its strangulated condition. The latter, after being thoroughly douched with sterile saline solution and warmed up with hot towels, was carefully examined, and, no injury being discovered, was returned into the abdomen. The right half of the abdominal cavity was filled with blood-clots, hæmorrhage having come from divided vessels in the muscles

of the walls; these were removed and the cavity washed out with a saline solution, allowing about a pint of the fluid to remain in the belly. The upper portion of the wound was closed with a continuous suture of catgut, layer by layer, leaving an opening at the site of the original cut, through which iodoform gauze was packed into the abdominal cavity. The lacerated parts below Poupart's ligament were allowed to heal by granulation. Temperature at close of operation was 97.8° ; pulse, 138. That evening the bowels were moved by an enema of glycerin and water, and next day his temperature was 99° ; pulse, 104.

Five days later, the boy having run an uneventful course, he was again etherized, the gauze pack removed from the abdomen and the wound closed with a continuous catgut suture. It was impossible to approximate the fascia and muscle at the lower portion, on account of the extensive laceration of these structures; as a result, a weak spot is left in the scar, inviting the formation of a hernia, and necessitating the constant wearing of a flat, hard-rubber truss. He was discharged from the hospital on the twenty-third day. At the time of writing the wound has healed, he has gained some twelve pounds in flesh, and is enjoying excellent health.

A similar case is reported by Ross (*British Med. Journal*, April 24, 1897, p. 1024). The patient, a sailor, was stabbed in the abdomen, sustaining a wound in the region of the right rectus, severing the epigastric artery. Eighteen inches of intestine protruded, coated with sand and gravel; there was also a penetrating wound of the thorax over the heart. "This man within a month made a good recovery, without a rise of temperature or any untoward symptoms."

In a case reported by N. Caine (*British Med. Journal*, August 14, 1897, p. 400), there was a self-inflicted wound, nine inches long, done with a razor, extending from above the symphysis pubis to two inches above and to the right of the umbilicus; through this opening there protruded the stomach, omentum, transverse colon, and all the small intestines. These were uninjured, replaced, and the man discharged perfectly well at the end of eight weeks.

In Wyeth's case (*Med. News*, January 4, 1896) of extensive laceration of the abdomen by a bull's horn, the wound was on

the left side, five inches long, extending from one inch above Poupart's ligament upward and backward, and through it protruded about fifteen feet of intestine. Wyeth did not see the patient till nine hours after the accident, when he cleansed, replaced the gut, and closed the wound, using a gauze drain at the lower end. The man recovered, and at the end of two years after the operation was none the worse for his accident, with the exception of a small ventral hernia at the site of the drain.

What should be the management of a case of evisceration? Hæmorrhage, of course, is the first condition requiring immediate attention; fortunately, however, it is rarely fatal, the bleeding vessels contracting or being compressed in the opening by the extrusion of the gut or omentum, which takes place rapidly. The possibility of a hidden hæmorrhage into or within the abdomen, however, should always be borne in mind, and this was the alarming symptom in our case. It is advisable to replace the protruded viscera as soon as possible; if for any reason this procedure is delayed, they should be douched with hot saline solution and protected by hot towels, wrung out of a 1 to 10,000 solution of bichloride of mercury. As a rule, it is best to provide some drainage. Particularly is this necessary if there has been extensive soiling of the peritonæum. Either the wound should be packed with iodoform gauze, running into the intestinal coils in all directions, and a secondary suture practiced, or a small gauze or wick drain should be employed at one angle, to be removed two or three days after the operation, and renewed until the discharge, if there is any, ceases.

After an extensive laceration, the patient is better kept in bed three or four weeks, or until firm union has been established, and when allowed to get up should wear some support—a belt, or, preferably, a flat, hard-rubber pad protecting the scar, held in place by a spring.

The two causes of death consequent to such an injury are shock and peritonitis.

In the case reported above there is no doubt in my mind that the infusion performed at the time of the operation saved this boy's life, as his condition was such that there were grave fears of his dying on the table.

There were no symptoms in the after course to lead us to

believe that he suffered from any great degree of peritonitis, the bowels were moved readily with enemata, the pulse, while high immediately following the operation, gradually came down, and the temperature remained within a safe range. While not positive that the protruding intestines had been rendered perfectly aseptic before their replacement, we had enough confidence in the absorptive power of the peritonæum to feel that it would take care of any degree of infection that remained. Moreover, a septic peritonitis would hardly be looked for without a wound of the gut, and escape of fecal matter among the intestinal coils.

The after-treatment was that usually following a laparotomy, with the exception that ice was kept on the abdomen continuously for the first 48 hours. Whether this had any bearing on his recovery I am not able to say; it seemed to give him considerable relief, and certainly produced no deleterious effect. It is the treatment usually followed at the Hahnemann Hospital.

CONSERVATIVE OPERATIONS ON THE TUBES AND OVARIES.

BY JAMES H. THOMPSON, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society, State of Penna., Phila., Sept., 1899.)

WE live in a period of unprecedented advancement along the line of enlightened progress, and it is pleasing to note that the gynæcological conservatism is awakening from the lethargy and considered the highest aim of surgery, and now the distinctive attitude of the newer and better surgery as contrasted with the widely prevailing radical methods of the last decade. As women possess organs which man has not, and as the parts—physiological and social—that she plays in life differ from those played by man, we should expect to find her afflicted with a certain number of diseases peculiar to her which are dependent upon her anatomy, physiology, and mode of life.

Conservatism is the effort to spare as much as possible of the pelvic organs during an operation, and to conscientiously avoid the removal of any organ or portion of an organ that is sound, as well as of organs or parts which, though not sound,

are deemed capable of regeneration. An argument in behalf of conservatism can be found in a report by Dr. W. M. Polk ("Are the Tubes and Ovaries to be Sacrificed in all Cases of Salpingitis?"). By his repeated demonstrations and earnest insistence upon the possibility of restoration of function in diseased adherent tubes and ovaries, and of the functional value of opened and amputated tubes, he has helped to lay the foundation-stones for the important conservative gynecological work in the immediate future. Conservatism is the general attitude of all true surgery on account of the value of the structures involved. Ovary and tubes are no longer removed *en masse* for purely technical reasons; but a diseased tube or part of a tube, a diseased ovary or part of an ovary, is removed by itself, each without interfering with the other.

The importance of the conserved structures to the welfare of the patient, and with the healthy performance of her functions in the recurring monthly fluxes, ovulation and the possibility of conception lie, though the woman may be unconscious of it, some of the deepest wellsprings of her future happiness. The removal of the sexual organs in woman is, in many instances, similar to the effect produced in a corresponding operation upon a man, disturbing her physical balance and bringing on a wretched state of confusion. It is still a matter for future demonstration whether or not their sequelæ are in all cases obviated by leaving in one or both ovaries when the uterus and tubes are removed and menstruation so checked. C. Schröder stated that one of his reasons for the preservation of part of an ovary was to preserve the function of ovulation, even if it were accompanied by but a theoretical possibility of conception.

It is probable that the ovaries, like the liver and thyroid gland, modify the blood circulation through them, and add to the blood some peculiar product of their metabolism. It may be that this wretched state of confusion, and some of the climacteric symptoms, are due to the loss of this substance from the system. It has been clearly demonstrated that when one ovary is removed the other undergoes a compensatory hypertrophy, increasing both in size and weight; the follicles mature and wither more quickly, and the medullary portion increases. Their changes begin within the two months after the operation,

and in three or four months the remaining ovary becomes nearly double its original size. Since the ill-effects of castration in women, whether the structures are diseased or not, are often so disastrous, it becomes a question of paramount importance to determine whether we can in any way substitute the lost ovarian tissue; and to this end E. Knauer has shown that the ovaries may be completely severed from their normal surroundings and successfully transplanted either to a part of the broad ligament or between the muscles of the abdominal wall.

The important conclusion may, therefore, be drawn that the ovaries may be transplanted even to a distant point, differing widely from the normal habitat, where they will not only grow, but will continue to develop normal Graafian follicles. It still remains to be shown whether these follicles rupture, and of what use transplanted ovaries may be with animal economy. R. Chrobak has tried, in the second line of experimental substitution of the lost ovarian tissue, that of feeding to the women deprived of their ovaries one of the various organic juices, and in a few cases with distinctly encouraging results. The ovaries of cows, dried and pulverized, and made into tablets containing 0.2 grain of ovarian substance each, were used, two, three, or even four tablets a day. The thyroid glands of sheep, treated similarly, have been used, and share, too, in some mysterious manner, in the processes of general metabolism. The result of broader clinical observations, associated with careful microscopical examinations of tissues removed, is a further reason for the advance made in conservatism, in the more intelligent discrimination experienced in regard to pelvic diseases.

There is the best clinical evidence to show that even a small bit of ovarian tissue left behind, or the stump of an amputated tube, may not only perform its ordinary functions, but may even contribute and carry an ovum to be lodged in the uterus, and go through the evolutions of a normal pregnancy. Old ideas no longer command respect simply because they come to us with the sanction of years. It is advisable, in removing par-ovarian cysts in which it is frequently possible by a simple, carefully conducted dissection, to extirpate the cyst, leaving behind the otherwise unaffected structures. So extremely important

are the ovaries that, if the circumstances justify it, even a small piece of sound ovarian tissue should be preserved. No age limit can be set upon the utility of the ovaries until it has been demonstrated that the internal secretion also ceases with the menopause, a conclusion which is for the present, at least, apparently at variance with the clinical facts.

Having removed one ovary, and when the opposite ovary appears perfectly sound and normal in size, consistence, color and outlines, I in all cases leave it, in a young woman. If it is enlarged, and there is reason to suspect disease, I remove it.

In extra-uterine pregnancy, tubal diseases, parovarian cysts, in hystero-myomectomy, hæmatoma, dermoid cysts and ovarian abscess, there is no reason whatever for the sacrifice of the ovary in removing a diseased or mutilated tube. While an ovarian cystoma commonly involves the entire ovary in such a manner as to prevent the isolation of any definite portion of normal ovarian tissue, in exceptional cases a part, and it may be even the greater part, of the ovary may be found unaffected by cystic degeneration at the base of the tumor.

In order to secure pregnancy it is not necessary to preserve the ovaries and the uterine tubes in pairs, as Kelly has shown by an operation where he removed the right tube and left ovary in March, 1895, pregnancy occurring in September of the same year, and the patient had her first child in June, 1896. In November, 1897, he had to remove the left tube for a ruptured extra-uterine pregnancy. It must be borne in mind, however, that there are other causes than the disease of the adnexa which conspire to keep down the percentage of pregnancies, as, for example, the fact that many of these patients are single, or, if married, the husband has gonorrhœa.

From what is written in the contents of this paper, I make the following condensed statement:

The surgeon must ever bear in mind that his relationship to his patient is not dissolved with the simple successful performance of an operation.

1. He must consider whether the pelvic ailments are sufficient to justify operation.
2. He is called upon to decide whether the symptoms the patient complains of are dependent upon pelvic lesions or are merely coincident with them.

3. Whether the remote sequela of operative interference may not be even more distressing to the patient than the present pains.

These topics will be found fully discussed by A. Hager, H. C. Coe and Dr. William Goodell, as to the effects of castration on women, in "*Symptoms versus Anatomical Cure after Gynecological Operations.*"

One of the reasons why it is difficult to get at some of the remote results of such an operation as castration, for instance, from the moral standpoint, is, that women are naturally reticent about matters of sex. Again, it must be remembered that many of these operations are performed upon poor women and those of the lower class who are ignorant and wholly unused to protesting against injury of any sort, and who accept life as it comes.

In weighing the effects of castration we dare not leave out of sight the common feeling that this particular operation is a degradation to women, and that the majority of physicians and all laymen look upon women deprived of their ovaries as unsexed. My own experience only serves to confirm my opinion that the castration of women is often a direct cause of domestic unhappiness, and that it has been repeatedly used by men as a good reason for breaking off engagements, and for the violation of marriage vows and the abandonment of wife and children.

The scarcity of literature on remote results is somewhat surprising, owing to the many surgeons who do not study their cases for several years after operation in order to learn the effects of extirpation of the pelvic organs. We ought now, with a greater lapse of time and an abundance of cases, to be in a position to answer all important questions as to the relationship between the various abdominal diseases and the remote sequelæ induced by the operation, invasion of the peritoneal cavity.

I do not propose to make an exhaustive investigation of this subject, but refer you to one of the first systematic investigations of this sort, made by T. Spencer Wells, of London ("*Ovaries and Uterine Tumors,*" 1882). It is computed that by his successful ovariectomies he gave back a sum total of thousands of years of life to women, not to mention the numerous children born to those in whom he was able to conserve one ovary.

In conclusion, I will say, as a general rule laid down, when the disease affects only a portion of a structure, the diseased portion should be removed and as much as possible of the sound tissue left, and if these organs are removed, the reason for the extirpation must be grounded in the actual conditions of the organ itself.

Cysts of the ovary are most frequently observed during the period of sexual activity, yet it is undoubtedly true that not only do the germs of many of these tumors date from fetal life, but that the actual formation of the neoplasm has often begun at that time, to remain latent until it receives some impulse which causes it to develop. This certainly occurs in the case of dermoid cysts, and many observations tend to show that it also occurs with proliferous glandular and papillary cysts.

The idea of conservatism is the willingness to try to save tissue, and particularly so as the gynæcologists are trying to save every part of ovarian tissue that is healthy. It seems to be the turn in the surgical affairs just now to puncture and to cut out cysts rather than to remove ovaries *en masse*. The claim is reasonable that a patient has saved to her organs that are necessary, and the sacrifice once made is now deplored.

In the traditions of general surgery, and its best principles all point toward conservatism as its highest goal, there are no reasons for making any exceptions to these rules in the special field of gynæcological surgery. This most radical procedure must be carefully guarded by operating only upon suitable and stringent indications. In young women, when the ovaries are not diseased, they must be left in the pelvis, confining the enucleation to the tubes and uterus. The removal of the uterus with the tubes and ovaries is to be recommended, because without the ovaries it is a useless organ, which may of itself, at a later date, become the source of such serious disturbances as to require its removal. In almost all pelvic inflammatory cases the uterus is traceable as the avenue of infection, and the retention of the same often insures the persistence of a leucorrhœal discharge, protracted hæmorrhages, and a sense of weight and pelvic discomfort which seriously mar the results of the operation. The backward displacement of the uterus onto the pelvic floor, when robbed of its adnexa, may also cause distress and obstruction of the rectum.

But we must recognize and combat the different pelvic diseases if we would bring comfort to these patients and obliterate a stigma that dims the lustre of our great art, gynaecological surgery.

ON THE METHODS OF SECURING ANTISEPSIS IN CORNEAL OPERATIONS.

BY GEO. W. STEWART, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Phila., Sept., 1899.)

It is somewhat surprising, in view of the vast revolutionary stride recently achieved by modern surgery, a stride made possible only by the perfection of an antiseptic technique, that the question of a safe, prompt and efficient method of securing antisepsis in ophthalmic operations is as yet in a measure undetermined. That the conjunctival sac contains bacteria, inordinate both in number and variety, is definitely understood. That in corneal operations their removal is a necessary *sine qua non* is likewise undisputed, but the adoption of a method most reliable and certain in securing this desirable condition remains unaccomplished, as evidenced by the total want of unanimity on the subject by writers and operators the world over. The reasons for this uncertain attitude are not difficult to ascertain. From our present state of knowledge, perfect asepsis can only be achieved by the employment of either chemical or thermic means. In the choice of any one particular agent, its effect in known germicidal strength upon the various tissues must first be accurately observed. The differences in susceptibility to irritation between the skin and mucous membranes and between mucous membranes of different regions must be carefully studied. The dangers resulting from actual chemical change within the tissues or the inducing of destructive inflammations are effects of the gravest importance.

All antiseptic agents in minimum germicidal strength are irritating in some degree, and on some structures more so than others. Diluted or weakened beyond their germicidal power, their efficiency in the production of asepsis falls distinctly below that of boiled water.

In general surgery, the chief object is to obtain a sterile sur-

face at the site of operation; this can be very effectually secured by vigorous scrubbing, and the employment of one or more of the various antiseptic agents at command. The production of a moderate irritation, or even slight cutaneous destruction, is by no means a formidable menace to success. In ophthalmic surgery, however, the reverse obtains. Vigorous scrubbing is obviously inconsistent, the selection of antiseptic agents is reduced to one or two, and even these must be diluted to a germicidal strength of questionable utility to insure against undue reaction.

The obstacles, therefore, in the way of securing a perfect asepsis in the eye by means of the ordinary measures are admittedly very great. The conjunctival and corneal structures exhibit a remarkable tendency to react from contact with even the mildest and safest dilutions of the most reliable chemical antiseptics. When it is considered that even slight irritations not infrequently become serious impedimenta in the course of corneal repair, the importance of excluding every agent that is liable to induce reaction to any great extent must not be underrated.

That effort has been constantly and systematically directed towards the discovery of more perfect measures there is no denying, with the result, moreover, of an excessively gratifying reduction in the visual mortality. To what extent this result may be due to a more perfected cleanliness, rather than to germicidal agents, remains to be considered.

Among the usually employed chemical disinfectants, bichloride of mercury ranks pre-eminently as the one most universally in use. I am convinced, however, that its utilization in ophthalmic surgery is based, in a certain sense, more upon a long familiarity with its antiseptic properties and extensive employment in operations on other regions of the body than upon a conviction of its sound practical value in corneal surgery. Experiments have conclusively demonstrated that the most frequently employed solutions of bichloride of mercury under all conditions do not manifest constant germicidal power; its action oftentimes is merely to inhibit germ growth—an action the value of which is as yet practically undemonstrated. Its inefficiency as a cutaneous germicide, even after immersion for twelve minutes in a solution so strong as 1-500, can with sufficient accuracy

be shown. That it unites chemically with the tissue albumins to form the albuminate of mercury is well known, which, while it may inhibit germ growth by encapsulation, becomes likewise a factor in the establishment of distressing irritation. Its value as an antiseptic depends entirely upon the strength of the solution, and in a solution sufficiently strong to exhibit its germicidal powers its irritant powers are inevitably manifested. From the experiments of Geppert, Behring, Schill, Abbott, Fischer, and others, we are taught that certain of the staphylococci resist the influence of a 1-3000 hot solution of the sublimate for more than twenty-five minutes, and that others are not always destroyed even after subjection to a 1-1000 solution for fifteen minutes. While weaker solutions may undoubtedly possess germ-destroying powers, a proportional length of time in which to exhibit their action is necessarily imposed, and this it has been shown extends over periods ranging from minutes to days. Finally, solutions of bichloride of mercury weakened to 1-10,000, when brought in contact with fresh wounds invariably cause a well-defined necrosis, easy of determination under the microscope.

Concerning other disinfecting agents, such as chlorine water, formaline, cyanide of mercury, Panas' solution of biniodide of mercury, etc., not generally in use, but still employed by some operators, there is little to be said, inasmuch as they have all been found distinctly irritating in strength sufficient to procure antisepsis, or of no practical value as germicides for ophthalmic purposes when weakened to a moderate degree of safety.

Presuming an operation on the cornea to have been performed with the requisite degree of skill and knowledge, there yet remains between absolute failure and success in some degree the all-important and essential requisite, to wit, a prompt and early union of the corneal wound. Before the theory of asepsis became converted into an axiom, the ever-immanent and constantly interposing contingencies in the way of this desirable issue were difficult, if not, indeed, impossible, to surmount. With the evolution and adoption of methods for securing antisepsis, fear of these contingencies has given place to a reasonable confidence and assurance of success. All things being equal, the primary union of a corneal wound, without undue reaction, can almost with absolute certainty be predicated.

The exact rôle enacted by chemical germicides in this extraordinary progress in ocular surgery is not difficult to ascertain, if the foregoing statements concerning their action be carefully analyzed.

It has been definitely determined that germicides in general, and corrosive sublimate in particular, are valuable as antiseptics only in solutions of known strength sufficient to destroy or inhibit the growth of pyogenic organisms. Such solutions, while available in other regions, cannot with impunity be instilled into the conjunctival sac, even in minimized intensity, without the dangers of resulting irritation. And, furthermore, solutions of minimum strength if not irritating are certain to become powerless as germicides by copious dilution with the lachrymal secretions.

It becomes, therefore, abundantly evident that ocular asepsis can never be even comparatively secured through reliance solely upon solutions of the chemical disinfectants.

An additional deterrent to the employment of sublimate solutions resides in the certainty of microscopic necrosis ensuing when presented to fresh surfaces. Unlike the possibilities of simple irritation, this danger is not minimized by the strength of the solution. While the presence of such necrotic tissue may not actually prevent the union of the corneal incision, the perils of delay and hindrance set up by its presence are sufficiently adequate to absolutely disqualify its use.

The common practice among many surgeons, notably those of New York, of instilling a solution of 1-5000 bichloride of mercury immediately prior to cataract extraction is mentioned only to be unhesitatingly condemned.

There being no known means whereby the conjunctival sac can be rendered completely germ free, ophthalmic surgery must perforce of necessity content itself with only an approximation to a perfectly aseptic state. Chemical disinfectants being excluded for the reasons enumerated, a serviceable asepsis is achieved only by means of copious irrigation with sterilized solutions unirritating in quality, of which the salt (sodium chloride) solution 0.6 per cent. is infinitely to be preferred. This, combined with a gentle wiping of the everted lids and adjacent conjunctival structures, so diminishes the number of bacteria present as to render the danger of wound infection from this source practically null.

The possible danger of wound infection, however, is by no means eliminated when an approximately aseptic state of the conjunctiva is all that is attempted. There still remains to be disinfected the external integument, brow, margins of the lids, and lashes, canaliculi, lachrymal sac, instruments, dressing, the hands and person of the operator and assistants, pillows, towels, etc. In short, the all-inclusive environment of the patient before, during and subsequent to the operation should receive the most searching antiseptic treatment, to avoid carrying infection into the wound. Only after this has been scientifically accomplished can we talk or write of aseptic surgery in relation to corneal operations. The methods employed for the purpose are the very accurate ones commonly in vogue, and are too well known to require discussing.

The treatment of cutting-instruments obviously necessitates the utmost care and precision, inasmuch as their delicate edges are readily damaged by subjecting them to the process ordinarily employed for the sterilization of instruments. Plunging them momentarily in boiling water, subsequently in alcohol, and scrupulously cleansing them with sterile cotton dipped in alcohol, will suffice to render them perfectly aseptic and preserve uninjured their cutting edges.

Again, as a source of infection the lachrymal duct is too frequently overlooked. With the dressings applied after operation, the puncta are more inverted and brought into closer relation with the corneal wound. Should undue reaction ensue, the lachrymal and conjunctival secretions become temporarily checked, and drainage through the canaliculi is thereby suspended. Under these circumstances the direction of drainage may easily become reversed, and the eye receive back again a multitude of infectious germs that under ordinary conditions are being continuously flushed in the lachrymal sac. Thorough disinfection of the sac before operation suggests itself, therefore, as a simple and logical procedure to prevent the introduction of infection from this fertile source.

To recapitulate. An ideally perfect aseptic state of the conjunctival sac is impossible to obtain.

Chemical germicides are absolutely valueless as such in strength that may with safety be employed in corneal operations.

The inevitable necrosis on the surface of fresh wounds following exposure to the influence of sublimate solutions in any strength imperatively excludes its employment during the making or healing of corneal wounds.

An approximate asepsis of the conjunctival sac can with certainty and safety be obtained only by thorough and liberal irrigation with sterilized salt solution.

A rigid and painstaking antiseptic technique should attend the performance of all operations of the cornea.

In conclusion. To many it may seem rather an exaggeration of the danger to reopen the discussion of antiseptics at this late date and urge the plea for more stringent precautionary measures. Some very recent operations in Continental Europe convince me, however, that carelessness and inaccuracy respecting ocular asepsis can supersede sound judgment, even in high places.

THE SURGICAL SIDE OF OBSTETRICS.

BY D. C. KLINE, M.D., READING, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Sept. 27, 1899.)

THE watchword everywhere at the close of the nineteenth century is progress; progress in all the arts and sciences. We progress in our manner of living, progress in our methods and manner of travel, progress in our implements of war, on both land and sea; hence make war more destructive and terrible, therefore of shorter duration. We progress in the prompt administration of law and justice; progress in the practical application of theology and religion to the present-day needs, thereby endeavoring to protect our weaker and downtrodden Cuban brothers.

Now, why should we not make greater progress in our methods and manner of protecting our suffering wives and sisters, and this particularly after they have marched through a nine-months' travail and entered into a battle, not with the purpose of destroying life (as in other battles), but with the hope of giving forth a human life? Here we should be ready and willing to put forth our every energy, and bring into action

our every faculty, thus giving them every possible attention and aid. We have not as yet come to consider obstetrics with that serious care which the subject deserves. We constantly hear so much of higher and more thorough education for the medical student, with additional examining boards to stand midway between the colleges and the State (all of which is proper), and yet allow a poor woman's life, as well also that of her offspring, to be jeopardized during one of the greatest ordeals of her life by the attendance of an ignorant and illiterate midwife—one who knows absolutely nothing of anatomy or physiology; a woman who entertains no conception of asepsis or antisepsis; one who has never spent a day in any institution of learning, with the idea of preparing herself or receiving any instruction in the art or science of obstetrics. This we believe to be radically wrong, and a halt should be called; no one should be allowed to practice the art of obstetrics except they have been properly and scientifically educated and licensed for that particular branch of medicine. We would not consider it rational to allow a class of uneducated men or women to practice surgery, who have received no special training in that branch of medicine.

As previously stated, we are progressing in other avenues of life, and likewise have we advanced in the art of obstetrics; nevertheless, there is room for vast improvement; we must come to regard obstetrics as *surgical* in character. The lying-in room should be cleaned and prepared in much the same manner as though an important surgical operation was to be performed. The bed and bedding should be clean, patient bathed, bowels emptied, genital organs scrubbed and disinfected; in brief, everything arranged and done aseptically. We are, however, moving in the right direction. Our patients, as well as physicians, are coming to understand and appreciate the decided advantages of hospital facilities; and why not? The uterus is an exceptionally secreting organ, and we are almost certain to have lacerations or abraded surfaces; hence would it be at all irrational to deal with an obstetrical case with nigh the same strict care that we do in abdominal sections? With a competent trained nurse and a little extra effort the patient can, of course, receive much the same attention in a comfortable home as in the hospital, just as other surgical operations

can be done in private. And yet we all prefer the hospital, believing that, as a rule, our patients are safer with the thoroughly aseptic surroundings, and removed from home environments.

It is a self-evident fact that many physicians do not have hospital advantages, or even the assistance of trained nurses. Here allow me to suggest that you can readily instruct an intelligent woman to be of great service to you. Select one in your community, and teach her yourself to give the douche, enemas, bathe the patient, use the catheter, take and record the temperature and pulse; make her understand the difference between being "socially or æsthetically clean and surgically clean," and, after a little practice, you will be surprised to find what a valuable assistant she will prove to be. (This manner of training is, of course, only suggested to render assistance where a thoroughly-trained nurse cannot be secured.)

The average physician should go to an obstetrical case prepared to cope with almost any emergency that may arise; his obstetrical bag should at least contain forceps, chloroform, ergot, hypodermic syringe, brandy, veratrum viride, morphia, needles, catgut, silk and wire sutures, dull curette, dressing forceps, sound, catheter, bichloride tablets, carbolic acid, boracic acid, scissors, iodoform gauze and powder, plain sterile cotton and gauze, vaselin, or, what is preferable, boiled soap; fountain syringe, and rubber sheeting, unless he is aware that the family possess the two last-named articles.

Immediately after delivery the perinæum should be examined, and, if there be a slight laceration, it can easily be repaired at once by any physician who is competent to deliver a woman or worthy of being called doctor; if one or two sutures will remedy the injury, it can readily be done without an anæsthetic, if repaired immediately, while the parts are somewhat benumbed from excessive pressure and stretching; even slight lacerations should be remedied. If, however, the laceration is extensive, extending well back or into the bowels, a few hours' rest would preferably be given the patient, competent assistance secured, convenient and proper accommodations made; then an anæsthetic administered and a competent operator secured. Before repairing a lacerated perinæum, we should examine the cervix to see if any lacerations exist, and remedy

these first, if they be at all extensive. Prior to these operative measures for either cervix or perinæum, however, it is good practice to use the intra-uterine douche or dull douche curette, and thus remove all clots and *débris*; this will aid contractions and lessen the amount of lochia to follow which must pass over the repaired parts and may disturb union. In fact, if the intra-uterine douche or dull douche curette, with a suitable disinfectant, were used more frequently following labor, we would not only lessen the amount of lochia, but many times save our patients from an endometritis, causing an ugly leucorrhœal discharge, and many of the slight cervix lacerations would be repaired by Nature instead of the surgeon.

THE SANITARY USE OF WATER.

BY SILAS GRIFFITH, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pa., Philadelphia, Sept. 27, 1899.)

Water, as found in Nature. Sparkling in the diamond dew-drop; flowing from the fountain as clear as crystal; rolling in the mighty ocean waves; rising in gentle vapors from the earth and sea up to the cloud-regions, there to be distilled, condensed and aërated, ready to be distributed to the earth again in form of rain.

Cloud Water is pure, natural water, and because of its purity is a ready absorbent; it becomes contaminated as it falls in rain, especially in the beginning, for it becomes partially charged with impurities from the atmosphere, even before it reaches the earth.

Pure Water is the most essential requisite in the way of nourishment that can enter the human system. About 90 per cent. of our food supply is, in fact, only water. All drinking-water which is at all doubtful should be subjected to *chemical analysis* and to *microscopical examination*, but the only *absolute* test is the *physiological test*.

Spring Water.—Spring water is only as good as the source from which it comes. It percolates through sand; but at the same time it frequently takes up mineral substances, especially

carbonate of lime, which cannot be digested nor assimilated by the vital organs of the body. Therefore, when it gets into the blood by weak action of the kidneys it incrustates in the joints, muscles and nerves, and causes rheumatism and premature old age.

Slow Sand Filtration for the Water Supply of Large Cities.—On a large scale the slow sand-filtration process is the most effective plan of purifying water, in the absence of distillation. In slow sand filtration the bacteria are removed by an organic, slimy pellicle which forms on the surface of the sand under the water. After a few days or weeks the pellicle becomes so thick as to clog the flow, and the surface of the sand must be scraped off and a new surface exposed. This process removes bacteria almost entirely, but it does not remove mineral impurities nor sewage; this latter, however, is partially burned up by the oxygen contained in the water, while in distilled water the oxygen is entirely driven off and must be replaced artificially, but the mineral impurities by distillation are left behind in the still to be thrown away, and are thus entirely removed.

Boiled Water.—In the process of boiling water the oxygen escapes and the dregs remain, although it does destroy germs; filthy water supply should not be tolerated.

Filtered Water.—Individual domestic filters of the most approved kind are often of decided benefit for clearing water for special purposes, but in the present state of sanitary science the best are not considered continuously germ-proof.

Distilled Water.—Water to be distilled by a new-process water-still is placed in the retort or boiler, and as steam is generated it separates from the dregs, which are left in the boiler, and the pure steam is condensed and becomes water again. A very important part of the process is re-oxygenating it with pure air, in order to make it a perfect drinking-water. It is perfectly free from all germs.

THE ALUM TREATMENT.

For Treating the Water Supply of Large Cities.—A method of filtering impure water much advocated now by interested parties is the alum process. In this a solution of alum is mixed with the water, which by acting on the lime and other matter is decomposed and makes a light flocculent precipitate which re-

quires a long time to settle, and in doing so tangles up the bacteria and other impurities, and afterwards, when forced through a bed of sand, leaves these impurities behind. This is a more rapid process than that of sand filtration, and if it were possible to exactly apply and distribute the precise quantity of alum requisite, it might be reasonably safe, although even then slight traces of this extremely deleterious substance would be likely to remain.

But, as a matter of fact, this exact supply and distribution *cannot be secured*, because the amount of lime and other salts and bacteria *vary in the same day*, and even from *hour to hour*. So that the quantity of alum will either be insufficient to remove all the impurities from every portion of the water, and an absolutely equal distribution of the alum cannot be secured, so that the bacteria will come through freely, or else an excess of alum will have to be used, and that will appear in the filtered water, and if used for drinking habitually and constantly, serious *impairment of health* will result. It is said that fish will not live in water so treated.

As such waters are not only unsanitary, but also extremely destructive to steam boilers, it is to be hoped that the medical as well as the engineering profession may take cognizance of this proposed plan for the employment of these patented devices, and insist upon *Slow Sand Filtration*, which is now almost universally in use in the great cities of the world, and has been thoroughly tested by more than fifty years' practical experience.

Artesian Well Water.—Many persons think artesian well water is the purest, but this is often a great mistake. It is also a common notion that a *deep* well or a *bored* well is an *artesian* well, while *shallow* wells or *dug* wells are not; but this is also a mistake.

An artesian well is one which is carried down through an impermeable stratum of clay or rock, which thus forms a *water-tight roof* over the source of supply. This may be 50 feet or 3000 feet; it is an artesian well, all the same. This impermeable roof slopes off to higher ground in one direction or another, often for hundreds of miles, and finally reaches the surface. The rainfall gets under the roof, which may be sandy beneath and resting upon another water-tight stratum, and so fills this space; and when a well is bored down the

water rises and frequently overflows; but the water is liable to be charged with impurities and gases, especially under strong pressure down below, while the source of supply itself may be only a few miles away, where the stratum dips rapidly, and these impurities thus run down these channels and taint the water. Frequently, when such a well is started, even of a very good quality of water, the continuous flow for a few months or years will gradually bring down mineral contamination or other impurities, and the quality of the water will rapidly deteriorate. These wells are often carried through several strata before a good supply is reached.

Living springs, so called, are usually in character somewhat similar, breaking through strata at the foot of a hill. A few years ago a *mountain valley in Switzerland* was infected with typhoid fever. Shortly afterward this disease appeared with great virulence in another valley many miles away, and totally out of communication with the other. The inhabitants procured their drinking-water from a splendid spring in the neighborhood, while the other valley was drained by a creek which disappeared in the mountain. Investigations made by the government resulted in showing that a saline solution, when poured into the creek in the one valley, appeared in a day or two in the spring water of the other; but the filtration between was so perfect that solutions of boiled starch poured into the creek where it disappeared could not be detected by the iodine test in the water of the spring; and yet the typhoid bacilli obviously went through freely. This may be the case also with the water of artesian wells.

The only absolute test for the purity of the water is the physiological one, for the most brilliant and transparent waters are often the most dangerous. The typhoid bacillus has never been detected in ordinary running water, and the same is true of other pathogenic bacteria. When water is known to be unwholesome or grossly polluted, the source of supply should be changed. Slow sand filtration for large cities is a guarantee to some extent against accidental or sporadic infection.

Conclusion.—Taking the case of sanitary water service, then, in its broadest aspects, it may be said that domestic filters are frequently useful in a limited sense only, and for temporary use.

That *artesian* water or *spring* water varies with the source of supply.

That *creeks* or *rivers* with a large population along their banks are unfit sources.

That distilled water, however pure, must be thoroughly oxygenated by sterilized air in order to be perfect drinking-water.

The death-rate of a city largely determines the quality of the water used. The appearance of the water is no proof of its sanitary quality.

Muddy water, like that of the Mississippi, may be highly sanitary, while that of a lagoon may be as clear and sparkling as crystal, and yet be laden with death.

For clearing or purifying the water-supply of large cities the system of *slow sand filtration* as practiced in London and Hamburg is the only method which has thoroughly stood the test of *experience*. The habitual use of alum, of hydrochlorate of lime, or any such caustic or corrosive chemicals, is totally *inadmissible*.

Far more, even, than pure air is pure water requisite for civilized man, and it is the imperative duty of our honored profession, to which all look for safe sanitary counsel, to hold fast to and teach the truth, and point out the dangers which inevitably follow the violation of Nature's immutable laws.

SOME UNUSUAL ABDOMINAL CASES.

BY WALTER STRONG, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Penna., Phila., Sept., 1899.)

1. DISPLACED and movable horse-shoe kidney of the right side, with absence of kidney upon the left side.

2. Extensive abdominal adhesions involving the stomach, the result of repeated abdominal operations.

3. Removal of a large ovarian cyst under cocaine, with some observations upon the sensitiveness of the peritonæum.

4. Extensive deposit of fatty tissue upon the inner surface of the peritonæum, simulating an abdominal tumor.

5. Cæsarian operation.
6. Poro-Cæsarian operation.
7. Traumatic displacement of the liver.
8. Traumatic displacement of the spleen, splenorrhaphy, with report of the result three years after operation.

Abdominal surgery furnishes us with a great variety of cases, many of which are unusual and of special interest, and it has occurred to me that possibly a few such cases might prove of interest to the members of this Society. You have so frequently had your attention called to long lists of the more common abdominal operations that I am going to eliminate all such from this paper, and present for your consideration the essential details of a few unusual abdominal operations.

All of the cases here reported were operated at the Women's Homœopathic Hospital, Philadelphia, and to save unnecessary repetition I might explain that it is my custom to conduct all such operations under strict aseptic precautions, normal salt solution being employed for all solutions, mops and irrigation. Previous to operation the bowels are thoroughly cleansed by a brisk purgative (licorice powder), after which the patient receives no medical treatment other than the homœopathically indicated remedy. At the close of each operation the abdominal cavity is irrigated with sterile normal salt solution at a temperature of 110°, and the abdomen then closed with it full of this solution, which is rapidly absorbed into the circulation, thus reducing the attending shock and the patient's thirst to a minimum. Following operations a high rectal injection of salt solution is given, by means of a rectal tube, every three to four hours, until flatus is expelled, when feeding by stomach is commenced. Stitches are removed upon the tenth day, and patient is kept in recumbent position for one month following operation, thus most effectually guarding against the formation of a ventral hernia. For the following histories I am indebted to our resident surgeon, Dr. Russell, who has been my first assistant during the past eight years :

Displaced and Movable Horse-shoe Kidney of the Right Side, with Absence of Kidney upon the Left Side.—Mrs. C., aged 22 years; white; married; American. Admitted to the Women's Homœopathic Hospital October 19, 1898. Family history good, and patient has always enjoyed good health. Has had

one child, two years ago, after an easy and short labor. During the past three years has complained of a lump in the right side of the abdomen; this lump is very sensitive to touch, and the least exertion upon part of patient causes much pain and distress in abdomen, the pains being of a sharp, drawing character, and always aggravated by motion. Bowels regular and urine normal. Has been in two other hospitals for treatment of the present trouble, and at each of these institutions no diagnosis was made. Examination reveals a firm, regular, movable mass upon the right side of the abdomen, extending slightly to the left of the median line and just above the level of the umbilicus; is very sensitive to touch and freely movable; impulse from aorta transmitted distinctly. Diagnosis at this time reserved, and exploratory incision advised and accepted.

Operation on October 24th. Ether. Incision made in median line from the umbilicus upwards, abdominal cavity opened; examination through this opening reveals a firm, round, regular mass, located beneath the posterior peritonæum and freely movable beneath it. Abdominal opening enlarged, intestines displaced to the left and posterior peritonæum incised, mass drawn forward and inspection reveals a peculiarly shaped kidney; in fact, there are two kidneys joined together, end to end, in the form of a horse-shoe; the connecting bridge of tissue is quite dense and appears to be of kidney tissue. The convexity of the mass is directed upward and inward, and from the inner margin of each kidney springs a separate set of blood-vessels and two ureters, which latter remain separate and distinct, so far as the fingers can follow. Careful examination of the left flank in the kidney region reveals an absence of kidney upon that side. So we then decided that we had a most unusual condition to deal with, and only one line of treatment appeared to be indicated. The kidneys were now returned to their abnormal position upon the right side, and by means of several silk sutures were firmly attached to the underlying muscles; peritonæum was then stitched together over them by means of a continuous silk suture, and the abdomen closed without drainage.

Following operation there was nothing of importance to note, convalescence being rapid and uninterrupted, and no trouble with the function of the kidneys. Patient discharged

December 2, 1898, in a very comfortable condition. Examination at time of discharge reveals the mass located deep in the right side of the abdomen, is immovable, and only slightly sensitive upon firm, deep pressure.

This was certainly a most unusual case; in fact, so far as I have been able to learn, it is absolutely unique in surgical history. Even horse-shoe kidneys are very uncommon, and where found they are usually located one upon either side of the spinal column and connected by a thin band of tissue. But in this case we had both kidneys located upon the right side, and even in this abnormal position they were freely movable, while the connecting band was very firm and dense, appearing to be composed of true kidney tissue. Under the existing conditions I am not surprised that a diagnosis before operation was impossible. It was no doubt a congenital condition, and caused neither pain nor discomfort until it became movable and drew upon its attachments. The relief obtained was nothing more than we would ordinarily expect after the usual operation for a movable kidney.

Extensive Abdominal Adhesions Involving the Stomach the Result of Repeated Abdominal Operations.—Miss T., aged 19 years; white; single; American. Admitted to Women's Homœopathic Hospital February 3, 1899. The family history was poor, there being tuberculosis. Patient enjoyed excellent health until three years ago, when she was operated upon at another hospital for appendicitis, which operation only gave temporary relief and necessitated a second operation four months later. The exact character of this second operation is not clear, and I have been unable to learn its exact nature, but in it the incision was made in the median line, so that it was probably of an exploratory nature. This second operation also failed to give the desired relief, and the patient grew gradually but steadily worse, experiencing constant pain and distress in the abdomen, and persistent vomiting, together with an inability to thoroughly empty the bowels. So severe did these symptoms become that she finally submitted to another operation, which was performed about twelve weeks previous to coming under my care. This operation was for the purpose of breaking up intestinal adhesions, but was unsuccessful. Upon admission to the hospital, an examination revealed a greatly

distended abdomen, which was everywhere sensitive to the touch, but especially so on the right side—patient also suffering from persistent retching and vomiting, which distressed her very much; also inability to expel flatus or faecal matter. The patient was put upon liquid diet and medical treatment, but without any improvement. Finally her condition became so desperate that we advised operative interference, to which patient readily assented. Operation March 18th. Ether. Abdominal incision slightly to the right of the old scars. After much difficulty entrance was obtained into the abdominal cavity, where we found that adhesions existed in every direction and between everything. Abdominal opening was now extended from the pubis to the ensiform cartilage, and then commenced a systematic separation of all the adhesions. Where not too dense they were simply torn apart, but in many places it was necessary to divide them between a double ligature, and in several instances it was found necessary to repair rents in the intestines. The adhesions of the intestines to the old appendicitis-scar upon the right side were very firm and dense, as were also those to the upper portion of the median scar; at this point there existed very firm adhesions between the stomach and the scar, and it was with much difficulty that a separation was effected. Finally, after a lengthy and tedious operation, all the adhesions were divided, and then a systematic search was made for all raw surfaces, which were dusted with sterile aristol, as advocated by Meyer, after which the abdomen was closed in the usual manner. The shock following this lengthy operation, which had lasted nearly three hours, was quite considerable, but patient gradually rallied and an uneventful convalescence was established. The vomiting ceased and bowels commenced to move naturally; patient's general condition improved so much that she was discharged on June 12th, in apparent perfect health. This was certainly a most desperate case, and well illustrates the value of aristol in the treatment of intestinal adhesions, without which I am of the opinion we could not have secured so happy a result.

Removal of a Large Ovarian Cyst under Cocaine, with Some Observations upon the Sensitiveness of the Peritonæum.—Mrs. M., aged 61 years; white; married; German. Admitted to Women's Homœopathic Hospital October 22, 1898. Family

history fair, two sisters having died of tuberculosis. Puberty at 17. Married at 29. No children or miscarriages. Patient has had a persistent cough since a child, it having developed following an attack of measles. Has been troubled with asthma since 30 years of age, but the attacks have not been severe until three years ago. Menopause at 49. During the past two years has experienced a heaviness upon the right side of abdomen. About three months ago patient noticed an increase in the size of the abdomen, which has enlarged rapidly during the past two months. Complains of much pain and distress in abdomen; also from severe asthmatic attacks, which prevent patient from assuming the recumbent position; has frequent fainting spells; appetite poor; loss of flesh as well as of strength. Upon admission, patient is very much emaciated, extremely weak, pulse weak and irregular, breathing much oppressed. Examination of abdomen reveals the usual signs of a large ovarian cyst, which occupies the entire abdomen and is pressing everything upwards against the diaphragm. Examination of chest shows mitral lesion and asthma. Patient's general condition was such that a general anæsthetic was out of the question, so after plainly stating the existing conditions to the patient she agreed to an abdominal operation under cocaine, which I advised, but patient's condition was such that even the most sanguine amongst us hardly dared hope for a successful termination of the operation. Operation October 24th. Cocaine injected at three points in the proposed line for the median incision, and at several times during the operation a few drops were added to the cut surfaces—the total amount of cocaine employed in the operation being only one drachm of a 2-per-cent. aqueous solution, representing exactly one grain of cocaine. The abdominal incision was made with absolutely no pain to the patient. Some adhesions between intestines and sac were readily broken up, the contents of the cyst were slowly drawn off with a trocar, after which the cyst-sac was delivered from the abdominal cavity and the pedicle ligated in two sections. Abdominal toilet completed and wound closed with nine silk-worm-gut sutures, dry aseptic dressings applied, and patient returned to ward. Time of operation, sixteen minutes. Pulse before operation, 88; after operation, 116. Following operation patient seemed to improve, the wound healed kindly, and

all of the sutures were removed upon the eighth day. Upon November 2d patient had a severe attack of syncope, from which she never thoroughly recovered, and grew gradually weaker, dying at 6 P.M., November 4th.

To me this was a most interesting and instructive case. The mere fact of performing an abdominal operation with my patient conscious was a novel experience. The patient, according to her own statement, did not suffer much pain at any stage of the operation. Dividing the abdominal walls was absolutely painless. The separation of the adhesions caused some slight pain, while the traction upon the pedicle and the tying-off was the most painful portion of the operation. While operating, I made some mental notes upon the sensitiveness of the non-cocainized peritonæum. I discovered the parietal peritonæum to be but slightly sensitive to either touch or incision, while the peritonæum covering the intestines and various organs was quite sensitive to even touch. I also found the peritonæum to be very sensitive to heat, water at a temperature of 110 degrees being quite painful, and from my experience in this single case I can readily understand the confusion which exists at present regarding the sensitiveness of this delicate membrane. The operation well illustrates the great possibilities of local anæsthesia, and we were all very much surprised to learn that such a formidable operation could be carried out painlessly with the use of such a small amount of cocaine as a single grain. At a future time I hope to be able to present further details upon the use of cocaine in connection with abdominal surgery.

Extensive Deposit of Fatty Tissue upon the Inner Surface of the Peritonæum Simulating an Abdominal Tumor.—Mrs. R., aged 51 years; white; widow; German. Admitted to Women's Homœopathic Hospital November 6, 1896. Family history of tuberculosis and syphilis. Puberty at 16 years of age. Has had four children and no miscarriages. Enjoyed excellent health until three years ago, since when she has been troubled with diarrhœa and pains in abdomen. Pain in abdomen very severe at times, and always made worse by least exertion. Upon admission, examination revealed a well-nourished woman with a large, prominent abdomen; heart, lungs and kidneys are negative. Palpation of the abdomen reveals a large semi-solid mass in the right side of the abdominal cavity, immovable and some-

what painful to pressure; transmits aortic impulses very plainly. Also has much pain and sensitiveness all over the abdomen upon deep, firm pressure, which pain is usually referred to two points high up upon the right side of abdomen. Pressure causes some nausea; and is immediately followed by a desire for stool. Patient was kept under observation until November 24th, and as the pain appeared to increase, an exploratory operation was suggested and accepted. Operation November 25th. Ether. Incision in median line midway between umbilicus and ensiform cartilage; upon opening the abdomen we discovered a large mass of fatty tissue growing from the inner surface of the anterior parietal peritonæum, which was excised, and bleeding points caught with deep stitches. Then making a further examination of the abdominal contents, we discovered that the liver in the region of the gall-bladder was one mass of adhesions; abdominal opening was enlarged, and these adhesions broken up, revealing a greatly distended gall-bladder, which was completely filled with gall-stones. Gall-bladder brought to the surface and incised, evacuating a large amount of bile and pus, together with a large assortment of gall-stones; after all these stones had been removed we discovered three stones wedged in the common bile-duct which were finally removed; the edges of the gall-bladder were then stitched to the edges of the abdominal wound, and its interior packed, after which the abdominal opening was closed. Convalescence uninterrupted, and patient discharged on February 7th, at which time there still remained a fistula, which required another operation for closing in May. After operation we counted the stones which were saved, and found 166, the largest the size of a shellbark and the smallest the size of a large grain of rice, the weight of which was 420 grains.

The growth of fatty tissue in this case was a most unusual condition—one which I had never seen before, and one for which I have been looking ever since. Upon examination it gave the exact impression of a semi-solid abdominal growth, and was well calculated to puzzle the most expert. As soon as we found this condition we at once had explained the growth; but there still remained the pain to account for, and this led me to further explore the abdominal cavity, with the result already stated. Of course, I claim no credit for the fortunate

termination of this operation; I simply started with the idea of exploring for the cause of the trouble, and, in fact, I was only fortunate enough to make one of those lucky surgical blunders which we all meet with occasionally. The gall-bladder was greatly distended and suppurating, in fact at one point was almost ready to break; and with it all there was no evidence of jaundice, a fact which renders the case all the more interesting.

Cæsarian Operation.—Mrs. B., aged 26 years; colored; married; American. Admitted to Women's Homœopathic Hospital November 24, 1897. Family history good. Patient always enjoyed good health, but had Pott's disease during childhood. Had a miscarriage at second month one year ago. Upon admission patient was in advanced stage of labor, with a history of its having started forty-eight hours previously; no physician was called until the morning of admission to our hospital, and he, upon examination, recommended that she be removed to a hospital for treatment, which proposition was not accepted until evening. Examination revealed a vertex presentation, together with a very much contracted pelvis, in which the sacrum was very prominent. Measurements with pelvimeter were as follows: Antero-posterior six and one-half inches ($6\frac{1}{2}$), spines nine inches (9), crests ten inches (10). Patient's general condition fair, very nervous and somewhat weak. Cæsarian operation advised and accepted. Operation at 6.40 P.M. November 24th. Ether. Abdominal incision from pubis to ensiform cartilage; peritonæum divided the same length. Uterus delivered from the abdominal cavity, the base of uterus now encircled with a heavy rubber cord, abdominal cavity protected by means of sterile towels. Six-inch vertical incision now made in the anterior wall of uterus; living child delivered, together with placenta and membranes. The uterine cavity was now thoroughly cleansed and sterilized with boiling water and live steam, after which it was closed by means of seven interrupted sutures of very heavy silk, which were introduced into the uterine walls just short of the mucous lining of the uterus. Constricting cord of rubber was removed and uterine contractions stimulated by means of manipulations and application of hot towels. Abdominal incision closed layer by layer and a dry aseptic dressing applied. The after-history of the case is unimportant, excepting a small breast abscess, which was opened

December 10th, after which there was no trouble, the mother and babe being discharged January 24th in most excellent condition.

Such an operation is a most simple affair, and if deliberately planned so that all aseptic precautions may be observed, should yield brilliant results. To my mind the safest plan is to make a liberal abdominal incision through which the uterus may be delivered, and then the remainder of the operation is completed outside of the abdominal cavity. A short incision has absolutely nothing to recommend it, and materially increases the danger of septic infection from the contents of the uterus. The operation can be rapidly performed after the manner just described, and with the constricting band around the cervical portion of the uterus, which is not absolutely essential, it is practically a bloodless operation. In fact, I think the time has now arrived when this operation should cease to be looked upon as one of last resort, and I have no hesitancy in saying that I consider it to be safer than a craniotomy, and think it should be given the preference over it.

Poro-Cæsarian Operation.—Mrs. M., aged 22 years; white; married; American. Admitted to the surgical wards of the Women's Homœopathic Hospital at 4.30 p.m., July 2, 1899. Was married in July, 1898 and menstruated regularly until September 25, 1898, when menses ceased, the usual symptoms and signs of pregnancy developed, and confinement was expected about July 7th. Labor pains came on about eleven o'clock, June 29th, and the membranes ruptured at 3 a.m. the following morning; but progress was very slow, and upon the morning of July 2d several attempts were made to deliver with forceps under ether, but with no success, and it was finally decided to have patient removed to a hospital for the necessary treatment. Admitted at 4.30 p.m.; patient in a very weak and nervous condition, much nauseated from effects of ether, pains very severe and almost incessant. Examination reveals a vertex presentation, severe lacerations of the cervical tissues and a much contracted pelvis. Pelvimeter measurements as follows: Spines, ten inches (10); crests, ten inches (10); antero-posterior, six inches (6), with the sacrum projecting like a large mass into the pelvis very low down. Fœtal heart sounds doubtful. Advised Cæsarian operation and received the necessary consent.

Operation at 7.15 P.M. Ether. Long median abdominal incision through the abdominal walls, delivery of uterus from abdomen, uterine arteries under finger-pressure of assistant. Longitudinal incision through the fundus of the uterus (as advocated by Fritsch) with rapid delivery of the child, placenta and membranes. The pressure at uterine arteries by assistant was most effectual, there being no bleeding. Uterus failing to show evidences of contracting it was determined to remove the uterus and appendages, which was accomplished in short order. Abdominal toilet made, sutures introduced in the usual manner, dry aseptic dressing applied and patient returned to ward. Time of operation fifty minutes. The child, after being delivered, made a few feeble attempts at respiration and then died; but an examination of the child's head explained this, as it had been literally crushed out of shape in attempts at instrumental delivery. Recovery from shock was slow but complete, and all progressed very favorably until the fourth day, when the temperature went up to 105° , respiration to 60, and the pulse to 140. Examination revealed a double lobar pneumonia, for which she received the indicated remedy (bryonia), and the patient gradually improved, and was discharged August 5th in excellent robust condition. This case is a most excellent illustration of how much some patients can stand and yet recover. Here was a most unfavorable case, one which had been greatly mismanaged and weakened by instrumental manipulations which were anything but gentle, leading to extensive lacerations of the cervix, and yet the patient went through the formidable Poro operation, together with a severe attack of pneumonia. The decision here to remove the uterus was a most wise one in view of the possibilities of its being already infected, and while it makes the operation a far more difficult one it is, I think, a measure to be adopted in all cases where there is a suspicion of the uterine cavity having been infected. And I am of the opinion that in a very large degree the success of the operation in this case was due to the complete removal of the uterus.

Traumatic Displacement of the Liver.—Mrs. A., aged 30 years; white; married; American. Admitted to Women's Homœopathic Hospital January 21, 1898. Family history good. Patient always enjoyed good health, has had no children

or miscarriages. Shortly before being admitted to hospital, while upon a step-ladder cleaning, the patient fell, and in so doing hit the right side of the abdomen upon the blunt end of a post. Upon admission patient in state of extreme collapse, abdomen distended, sensitive and dull to percussion over the umbilical region. Patient taken to ward and put to bed, free stimulation, condition of patient gradually improved and shock passed off, but the abdominal pain remained. Further examination after patient's condition improved revealed the dull area to be due to a displacement of the liver, the liver having been dragged downwards and to the left. Gentle and long-continued manipulations were rewarded by a partial return of the liver to its proper location, where it was retained by means of the judicious use of padding and a firm abdominal binder. Absolute rest in bed upon the back was continued until all pain had subsided, after which a specially made abdominal support was secured, which the patient still wears. Patient was finally discharged upon February 11th, and since then she has been endeavoring to take things very quietly, with the result that she has had very little trouble.

This case fully demonstrates a fact which is so frequently lost sight of, and that is that nature can often repair a serious injury in a better manner than we. Here was a very unusual condition, a serious internal injury accompanied with much shock, which shock I am free to admit caused me to treat the case in the conservative manner in which I did, and as it terminated it is doubtful as to whether or not an operation could have secured as good a result as we did.

Traumatic Displacement of the Spleen. Splenorrhaphy, with Report of the Case Three Years After Operation.—Mrs. L., aged 33 years; white; married; Italian. Admitted to Women's Homœopathic Hospital October 13, 1896. Patient born in Central Italy, but has been in this country eight years. No history of ever having had malaria, and has always enjoyed good health. Has had five children and no miscarriages. Ten days ago patient fell down stairs and struck upon a bucket, striking left hypochondrium; since then has been confined to her bed and visited by a neighboring physician, but without relief. Upon admission complains of intense sharp pains in the left side of abdomen, extending upwards, and aggravated

by motion, pressure, or breathing. Much distress upon taking food, and some vomiting. Bowels loose and watery and accompanied with much pain. Examination of abdomen reveals a large sensitive mass upon the left side of abdomen, extending from under the left ribs downward to a point two inches below the level of the umbilicus, and extending well over beyond the median line. Very sensitive to touch and freely movable. Diagnosis of an acute displacement of the spleen was made, and patient put at complete rest. Patient insisted upon leaving hospital October 28th, but returned six days later worse than ever. Advised operation, either splenorraphy or splenectomy as the condition demanded, to which patient consented. Operation November 19th. Ether. Incision through abdominal wall at the outer border of the left rectus muscle from the ribs downward to the crest of the ilium. Examination revealed a displaced spleen, which was returned to its proper position and held in place in a manner which I have already described in a former article (*HAHNEMANNIAN MONTHLY*, January, 1898), and patient discharged cured December 31st.

This was a most unusual case, and one which attracted a great deal of attention at the time of the operation, inasmuch as I attempted a new operation which had been but recently suggested by several prominent Continental surgeons. And it is to make a further report upon this case that I have introduced it here. I have very recently had the opportunity of examining this patient, and I am pleased to report that the spleen is still firmly in place and causing no trouble or discomfort, and this in spite of the fact that the patient has been delivered of a child at full term since the operation. So after three years time this case is well, and I think can be safely recorded as a permanent cure.

STREPTOCOCCIC ALVEOLITIS.—Dr. J. Seitz records a case of streptococcic alveolitis in a very grave form, which closely resembled miliary tuberculosis, but which ended in recovery in the sixth week of the disease. The slight quantity of sputum which could be obtained never contained any tubercle-bacilli, but always only streptococci, to which the disease was attributed. He adds a record of several other similar cases, and asserts the necessity of developing the differential diagnosis between tuberculosis and other especially chronic lung diseases.—*Muenchener Medicinische Wochenschrift*, No. 48, 1899.

Frank H. Pritchard, M.D.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

OUR PUBLIC-SCHOOL SYSTEM.

It was just after having had conversations with the parents of several young patients, scholars in our public schools, and with a number of those engaged in teaching in the same schools, that we came across the following extract from an article by Edw. Bok in the *Ladies' Home Journal* for January, 1900: "Do American men and women realize that in five cities of our country alone there were, during the last school term, over 16,000 children between the ages of 8 and 14 taken out of the public schools because their nervous systems were wrecked and their minds incapable of going on further in the infernal cramming system which exists to-day in our schools? . . . It is putting the truth mildly to state that of all American institutions, that which deals with the public education of our children is at once the most faulty, the most unintelligent, and the most cruel."

Never have we uttered a more fervent, heartfelt "Amen!" than that with which we greeted these trenchant, truthful words.

We have referred to this subject before. It is one which not indirectly, but directly, concerns us physicians as conservators of the health of the families which have placed themselves under our care. The specialists are, indeed, called upon to repair the damage done; it is our duty to arouse and direct public opinion against methods which render such repair necessary.

In combatting the present system we are likely to meet with opposition not only from those who stand as its originators and advocates, but also from many of the parents themselves. These latter, although they see but too clearly the effects, still find in the apparent amount of knowledge gained the gratification of their own ambition for their children. Realizing the scantiness of the advantages they themselves have enjoyed, they are eager that their children should have all that they

have lacked. Who has not witnessed the pride with which some poor ignorant mother has referred to the number and difficulty of the studies required of her son, or, as is more frequently the case, of her daughter? While this attitude may in itself be entirely praiseworthy, it is open to very serious question whether it is conducive to the best interests of those most nearly concerned. To arrive at a correct standpoint for a consideration of this question, it should first be decided for whose special benefit the public schools exist, and for whom they are maintained. Strictly speaking, it must be acknowledged that, being supported by general taxes, the public-school system belongs to the community, and is for all children in the community, the children of the rich as well as the children of the poor. But are the needs and wants of all the same? Does the child of the poor laborer or the poor washer-woman require the same sort of education as that which the child of the rich, or even of those in moderate circumstances, will find necessary in order properly to fill his place in the community? Surely not. In adapting the curriculum to the wants of the one class, those of the other must in a measure be disregarded.

But it may be answered that this is only a theoretical objection, since practically its force is entirely destroyed by the higher grades in the common schools and by the advanced teaching in the high and normal schools. One moment's reflection will show that under the present system this is, however, not the case. It would be were the lower grades so arranged as to provide a full, rounded-out course in what is usually called a common-school education, adapted to the wants of those who, on account of their station and circumstances in life, are not able to continue to attend school long enough to complete the theoretically beautiful and symmetrical course. The entire course is a graded one, the various stages of which are so closely connected that not until it is completed can a child be said to have received the education which the public school is supposed to give him. What is the result? Numbers of scholars are compelled to leave with a very imperfect knowledge of the essentials of an education fitted to their environments, and this not for actual want of time, but only from want of time in the course as at present arranged. This is a piece of rank injustice to the poor, who have no redress. For

those who are able to afford it, the numerous private schools offer all the advantages which are now offered them in the public schools, to the detriment of the other less favored individuals. The poor have no relief, and therefore we maintain that the public schools should be for the benefit of these, and not for the higher education of those who are able to seek it elsewhere. By arranging the instruction in the lower grades, those containing scholars whose time of attendance is known to be limited, so that all which is essential to the requirements of that class of scholars should be given without regard to a possible completion in the grades above, the symmetry of the whole curriculum might, indeed, be destroyed, but the rights of those who need the public schools would be respected.

When we hear of such subjects as the following being taught in the schools where the attendance is made up principally of the children of foreigners but imperfectly acquainted with the simplest forms of our language, and entirely unaccustomed to mental effort, we find it tragically absurd: "What was the Embargo Act?" "Give the origin of the various political parties." "Describe the rise of sectional feeling." These are some of the subjects required to be presented and explained to children from 9 to 10 or 11 years of age, in a section principally inhabited by Italians and foreign Jews. Does this not seem like education (or educators) run mad? Would not the old and now despised and rejected "three R's" be preferable to such rot? (We should, perhaps, beg pardon for the use of the last rather inelegant word, but we are unable to select any other capable of doing justice to the case.)

We do not hesitate to say that we think there is too much of so-called education at the present time; others, with more influence, have said the same. A little learning is a dangerous thing. A partially advanced education, unfitted to the station of the one receiving it, can only be a source of danger. Its possessor becomes unfitted for his surroundings and for the duties which are inherent to those surroundings, and on arriving at adult years he becomes discontented with his lot, without either the talent or the mental development necessary to enable him to rise by his own merit. He seeks the fault not in himself (the superficial character of his training has unfitted him for self-knowledge), but in the superior external advantages of others. From the ranks of such half-

educated malcontents is recruited the army of those who will always form the greatest menace to the stability of the social fabric.

Where talent and merit exist there is always found a way to make them count, as the numberless instances of the achievements of self-made men and women amply prove. Such make their circumstances, and are not made by them.

Were only the rudiments of an education imparted to the children of the poor, in such a manner, however, as really to train the mind and develop the intellect, we would have less to fear from the illogical oratory of the blatant nihilist and the wheedling imperiousness of the "walking delegate."

Again, the system, apart from its injustice and practical incompleteness, is quite at variance with the acknowledged fundamental principles underlying the real acquisition of knowledge. If there is anything universally accepted as a truth by psychology, it is that for the development of the mental faculties in any direction concentration and repetition are absolutely requisite. Are these at all possible in the "infernal cramming system which exists in our schools?" Can we expect any true education from the present system, with its ever-increasing number of fads and frills? Can a mind be healthily developed and trained when its energies are being constantly frittered away on a multiplicity of unrelated subjects, many of them necessarily presented only in a superficial manner, and without that repetition which is so essential to proper mental assimilation? Is it to be wondered at that so many finally succumb in their efforts to maintain their standing in class? Is it not rather a subject of astonishment that any survive? Coming, as this mental strain and exhausting nervous trial usually does, just at the time when all the forces of the physical nature are engaged in adapting themselves to the changes accompanying puberty, could anything be more cruel and more threatening to the well-being and health of future generations than the present system?

Is the present system necessary? From what has been said, it is apparent that we do not concede its utility as a means of mental training, and, as far as the practical side of the question is concerned, it needs but a glance at the subjects presented, the character of the knowledge actually acquired, and the uses to which it can be put in later life, to see that from

this point of view it must be regarded as a costly failure. The attempt which seems to be made to give scholars at this period of their lives almost a universal conspectus of knowledge can only result in weakening the power of concentration, and therewith the power of acquisition, at the same time that it puts in the place of a solid knowledge of practical subjects a superficial acquaintance with many unpractical facts, to be forgotten as soon as possible—the sooner the better, except by those who are being trained to perpetuate the same absurd system.

We hope that interest in this vital question may be aroused in the profession to the point of actively antagonizing the cramming system, not only in private but in public, and that wherever physicians succeed in obtaining independent positions upon school boards their efforts may be directed to substituting a system based upon acknowledged laws of physiology and psychology, and not upon the notions of enthusiastic theorists.

THE HAHNEMANN MONUMENT.

DR. JAMES H. McCLELLAND, after a long-continued, well-sustained effort, reports that the United States Senate and House of Representatives recently passed, practically unanimously, a bill granting a site in Washington, D. C., and appropriating four thousand dollars to build the foundation for the Hahnemann Monument, and that President McKinley signed the bill.

The Site Commission, after protracted consideration, finally agreed upon the Scott Circle, which is recognized as the most beautiful and prominent site in Washington.

Dr. McClelland, with an assurance in keeping with his splendidly ambitious project, announces that the corner-stone will be laid in May, 1900, and that the monument will be unveiled and dedicated in June, 1900, during the session of the American Institute of Homœopathy.

Triumphant over seemingly insurmountable obstacles, Dr. McClelland is persistently forcing the monument to a successful completion, and if his associates in the profession will exercise but the hundredth part of his continued self-sacrifice, every dollar needed to pay for it will be in the treasury before June 1, 1900. The monument is completed in every detail, and it will take but a few weeks to assemble the parts and erect the same in the city of Washington as a lasting honor to Hahnemann, to the glory of the profession, and to the adornment of the National Capital.

It is time now to do your part. If you have done so, do it again, and set an example worthy of emulation to the laggards.

GLEANINGS.

A CASE OF MIXED TYPHOID AND MALARIAL FEVERS.—Dr. Bevans reports a rare case of simultaneous occurrence of typhoid and malarial fevers. This patient was admitted to the hospital on October 4th, with a temperature of 102.4° F.; tongue coated; abdomen tender; the liver and spleen were somewhat enlarged; his mental condition dazed. By October 7th rose spots had developed, and he was in an active delirium. Light chills occurred daily. On the 11th the chill was prolonged and severe. Malarial parasites were first found in the blood on that day. Delirium continued until the 25th. The temperature, course and symptoms after the 13th were those of typhoid fever. Temperature reached normal on the 29th, and slow convalescence took place. The “Widal” reaction was absent until November 9th, twelve days after the temperature had become normal.—*New York Medical Record*.

Herbert P. Leopold, M.D.

THE PHYSIOLOGICAL ACTION OF HEROIN.—Dr. Eugene Medera (Italy) has made some observations on about fifty cases, the greater number of whom were suffering from various diseases of the respiratory tract, while the remainder were patients having no affection of these organs.

In nearly all the patients the remedy was administered by the hypodermic method. For this purpose he made use of the hydrochloride of heroin, for the reason that this preparation is very soluble in water. The initial dose was about 8 milligr. (gr. $\frac{1}{8}$ to $\frac{1}{4}$); this dose was sometimes increased to 1 centgr. ($\frac{1}{10}$ gr.), with the following effects:

1. A diminution in the frequency of the respiratory movements. In general the diminution varied per minute between six and eight respirations.

2. Contrary to the experience of most observers, he was able to note a diminution in the number of arterial pulsations, which commonly averaged seven or eight pulsations to the minute. This was especially marked about forty minutes after the injection. He was not able to establish a constant relation between the diminution of the arterial pulsations and the lessened frequency of the number of respirations.

3. Somewhat less constant, yet sufficient to allow of formulating an opinion, were the results obtained in regard to the behavior of the blood-pressure. In most of the cases a diminution of the pressure was observed, which often was manifest within twenty minutes after the injection, but usually reached its maximum in about fifty minutes. In general, it averaged from ten to fifteen mm. (There are great difficulties in the exact valuation of the numbers given by the sphygmomanometer; the average pressure in man is from 120 to 150 mm.)

4. He was generally able to observe a slight fall in the temperature, usually noticeable in about twenty minutes, and still more so after thirty or forty minutes. On an average it usually fell about three-tenths of a degree C.—*The Charlotte Med. Journal*, January, 1900.

Herbert P. Leopold, M.D.

IS CANCER OF VEGETABLE ORIGIN?—The *Medical Times* (February, 1900) reviews the investigations of Fiessinger, a country physician in France, whose evidence seems to confirm the recent assertions of Bra. Fiessinger is convinced that cancer is highly contagious, being transmitted in families, and even through the medium of infected houses. He also goes so far as to maintain that it is especially frequent in sylvan districts, and that the majority of its victims are found among dwellers and laborers in the woods, rather than in villages and large towns.

Following out his theory, M. Fiessinger endeavored to discover the insect which was a carrier of the parasitic cancer germ—for, of course, such a germ must exist. It occurred to him that the common canker (*carcinoma*, it is technically called) on the bark of trees most nearly resembles the malignant neoplasm so fatal to animals and man. These morbid growths appear on full-grown trees as the result of a wound, however inflicted, and it is a fact well known to woodsmen that they are decidedly contagious, forest trees thus affected being found grouped together, usually. Such excrescences have very much the appearance of cancer, and run in all respects a similar course. Treatment is the same in both cases—lopping off the diseased branches, and, in man, excision of the infected tissues.

A case in which the contagion was apparently conveyed directly from the vegetable kingdom to man is instanced. A gardener, while pruning a cankered apple tree, chanced to cut himself on the lip with his knife. Before long an epithelioma developed at the seat of injury, recurred after operation, and speedily proved fatal.

From a close study of arboreal cancer Fiessinger concludes that it originates in a penetration of the bark by various species of fungi, one of which is known as *nectria ditissima*. The question next arose: Does human cancer contain spores, and, if so, may they not be the same as those of the disease in trees? There seemed nothing to forbid the supposition, and quite lately it was confirmed by the researches of Bra and his discovery of the alleged germ of human cancer. The latter, when carefully examined, turned out to be identical with the *nectria ditissima*. Inoculation of animals with the latter gave rise to an ulcer, which gradually changed to genuine carcinoma. And, conversely, Bra inserted cultures from human and animal cancer germs (it mattered not which) beneath the bark of trees, and produced the cankerous lesions, in which were found spores of the *nectria ditissima*.

These observations, fanciful though they seem, are said to have been completely verified by subsequent investigators.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF HEART DISEASE BY INHALATIONS OF CARBONIC ACID GAS.—Ewart, of London (*Therap. Gaz.*, Dec. 15, 1899), maintains that this treatment brings within the scope of Nauheim therapeutics a considerable number of cases that would otherwise be set down as unfit; indeed, he attributes much of the efficacy of the Nauheim bath treatment to the incidental inhalation of carbonic acid gas. Whereas balnear treatment exercises its greatest influence over the period of recuperation, the inhalation treatment is indicated in the stage of failing cardiac energy. Ewart asserts that those cases will derive most benefit in which the elements of respiratory distress and cardiac pain predominate.

Like many other drugs that in large doses produce a toxic effect, carbonic acid gas has in lesser dose an active physiological effect. It would seem that none of the gas inhaled passes directly into the blood stream, but by raising the pressure in the lung it prevents the liberation of some portion of the same gas already in the blood. Short of the asphyxial state induced by large doses of an irrespirable gas, Ewart enumerates the following as the chief physiological effects of small doses inhaled experimentally in moderate concentration :

1. A feeling of internal warmth, and after a time some flushing.
2. A strong desire to breathe, and particularly to breathe out.
3. An excited state of the circulation, which may amount to throbbing or palpitation.
4. A slight giddiness, and headache supervening after awhile in some susceptible subjects.
5. General anæsthesia is not brought about by moderate inhalations.
6. Cutaneous anæsthesia has not been obtained as a result of the inhalation, but only by the action of the gas upon the skin.

Side by side with these effects of the inhalation of carbonic acid gas on the healthy subject, Ewart sets the observations of its effects on patients with cardiac symptoms. The subjective effects are :

1. Rapid diminution or cessation of cardiac distress or pain.
2. A feeling of increased freedom of respiration.

The objective effects are :

3. A visible increase in the depth of respiration.
4. A marked improvement of the pulse.
5. An obvious improvement both in the complexion and expression of more than transitory duration.
6. By systematic repetition, progressive improvement in the patient's general condition, as well as in the cardiac and respiratory functions. Thus it will be seen that the direct effect upon the cardio-vascular system is reinforced by the greater range of respiratory movements which, so to say, open up wider channels by which the blood may find its way through the lungs.—*Med. Times*, February, 1900.

F. Mortimer Lawrence, M.D.

THE PATHOLOGY OF LOBAR PNEUMONIA AS A BASIS FOR TREATMENT.—Dr. Andrew H. Smith, in presenting a paper with the above title to the New York Academy of Medicine, maintained that lobar pneumonia was not an inflammation of the lung, but a culture of the pneumococcus, and that the peculiar features of the disease were dependent upon the special conditions existing in the lung. He directed attention to the presence of a double circulation in the lung, and insisted most strenuously that pneumonia has to do with the functional circulation, while the life of the pulmonary tissue is maintained by the nutrient circulation. The growth of the pneumococcus in the fibrinous exudate in the air-cell was the essence of pneumonia. In considering the treatment, he dwelt upon the possibility of inhibiting this germ-growth by suitable medication of the blood from which the exudate is derived, and took the position that owing to the feeble vitality of the pneumococcus and the fact that the blood could be saturated readily with such substances as chloroform, sodium salicylate and creosote, it was entirely possible by that means to prevent the disease from spreading to other air-cells.

Those who participated in the discussion of this paper disagreed with its author, and expressed their continued belief in the older theory that pneumonia is a true inflammation.—*Phila. Med. Jour.*, November 18, 1899.

F. Mortimer Lawrence, M.D.

THROMBOSIS OF THE VEINS IN CHLOROSIS.—Dr. Otto Leichtenstern calls attention to the possibility of the formation of thrombi in the veins in about 2 per cent. of chlorotic cases. His statistics show the great predominance of these in the lower extremities and the cerebral sinuses. Pregnancy and chlorosis both favor their development. If small or deep veins be involved, then there may be a complete latency of the condition, due to absence of the pathognomonic signs, œdema and pain; and if deep-seated, the pain may be ascribed to fatigue, a neuralgia or a myalgia, and massage, exercise and gymnastics are prescribed, which particularly favor the appearance of the dreaded complication, *pulmonary œdema*. If pain and œdema be absent, the state may be completely concealed. The consequences of this clinical latency of chlorotic thrombosis of the veins is illustrated by a case which he observed:

A well-formed, strong and large young woman of 23 years, who entered the hospital on account of pains in the calf of the right leg and popliteal space, which was sensitive to pressure, with complicating moderate œdema of the ankle, dorsum of the foot and lower portion of the leg. Chlorosis in a moderate grade. Chlorotic thrombosis of the poplitæ and veins of the calf was diagnosed. She was put to bed, the limb elevated, and cold compresses removed the pain and œdema in a few days. In a week she scarcely was to be kept in bed, demanded her discharge, etc. Then one morning at 3 A.M. she got out of bed for the first time and walked to the faucet nearby to get a drink. In returning to her bed she was suddenly seized with terrible anguish and dyspnoea; she rushed to the window, threw it up, and raving and struggling for air, cried out, and if she had not been forcibly caught and pulled back she would have fallen out. Her face was as pale as a corpse, her breathing was deep and rapid. This terrible agitation, with a veritable "air-hunger," lasted almost half an hour, when cyanosis, sopor and the symptoms of pulmonary œdema were followed by death at 5 A.M.

Such a case needs no comments; it teaches us to watch cases of chlorotic thrombosis and to keep them quiet, even after the clinical symptoms have disappeared. The necropsy revealed the popliteal and veins of the calf closely filled with friable, different-colored and adherent thrombi, the femoral veins, on the contrary, empty. This complication has been noted to occur ten times in fifty-two cases of chlorotic thrombosis, in nine with an immediately fatal result, the clot is so liable to lacerate—more, indeed, than in any other form of thrombosis, except in the puerperal variety.—*Muenchener Medicinische Wochenschrift*, No. 48, 1899.

Frank H. Pritchard, M.D.

MENINGEAL HÆMORRHAGE WITH KERNIG'S SIGN.—Dr. Widal observed a case of meningeal hemorrhage where Kernig's sign was present. A man of 38 was suddenly seized, while seemingly completely well, with an apoplectic-form attack. Returning to consciousness after several hours, he presented neither fever, paralysis nor contracture. He only complained of an intense headache, lumbar pains, with slightly dilated pupils. Besides, Kernig's sign was observed, which led to a suspicion of a meningeal lesion. Indeed, while in

the dorsal position he could keep his legs extended, but if seated on the edge of his bed they would flex upon his thighs. Five days later the temperature rose to 38° C., and varied between that and 38.8° until death, which occurred in syncope on the ninth day. During the preceding days slight contracture of the muscles of the back of the neck. The necropsy revealed a clot in the inferior subarachnoid space, which was prolonged downwards onto the protuberance, the bulb, and the anterior surface of the spinal cord. The spinal canal was full of blood. This clot affected neither the convolutions of the base nor those of the convexity. This goes to show that Kernig's sign may be present without any inflammation of the meninges of the convexity being present; indeed, Dieulafoy has of late asserted that it was dependent on an irritation of the spinal meninges. If it be more often absent in tuberculous than in the cerebro-spinal form, the rare involvement of the spinal meninges in the latter affection would explain this.—*La Semaine Médicale*, No. 51, 1899.

Frank H. Pritchard, M.D.

A PATHOGNOMONIC SYMPTOM IN HYSTERIC PARALYSIS OF THE EXTREMITIES.—Dr. R. v. Hoesslin in diagnosing the hysteric nature of a paralysis has the patient make a movement with the extremity, as, for example, extension or flexion, with exertion of a corresponding degree of resistance on the part of the examiner's hand. Suddenly the resistance is removed, while the opposing movement is being made. In a paralysis dependent on an organic lesion the limb starts forward like a spring. On the contrary, in functional (hysteric) paralysis the movement is held back or inhibited at the same moment that resistance ceases, and only after a pause is it continued. This depends on the contraction of the antagonist muscles. He calls it paradox contraction of the antagonists. These two signs, the absent "springing movement" on cessation of resistance and the contraction of the antagonizing muscles, may be readily demonstrated even in the many muscular weaknesses which precede or accompany hysteric paralysis, even if these groups of muscles are not paralyzed. If complete hysteric paralysis be present and the test is impossible in the affected limb, then other groups of muscles will yield this reaction.—*Norsk Magazin for Lægevidenskaben*, No. 11, 1899.

Frank H. Pritchard, M.D.

HÆMATOPHILIA, WITH JOINT MANIFESTATIONS (HÆMARTHROS); CURED BY INJECTION OF A SOLUTION OF GELATIN.—Dr. F. Krause presented a young hæmatophilic of 15 years, whose uncle bled to death after extraction of a tooth, and who had been affected much in childhood from epistaxis, and since his eighth year had suffered from swelling of several joints simultaneously. On account of the known inefficiency of treatment in such cases and the excellent results from injections of gelatin in aortic aneurysms, this means was tried with astonishingly good results. While previously the joint the next day after puncture and irrigation would be fully as swollen, and after removal of the soaked dressings the blood would spurt out in a stream, now, after injection into the joint of 200 cems. of a 1 per cent. solution of gelatin in a salt solution, not another drop of blood flowed out. Later 200 cems. of a 2½ per cent. solution were injected five times, partly subcutaneously or into the joint itself. The patient, who had become greatly reduced in strength and anæmic, now recovered, and no further hæmorrhages have since occurred.—*Muenchener Medicinische Wochenschrift*, No. 47, 1899.

Frank H. Pritchard, M.D.

TRAUMATIC RUPTURE OF THE BILE-DUCT.—Garrett (Kingston, Ontario) reports a successful case of rupture of the bile-duct. The patient was a well-developed man of 21 years, who was caught between two heavy beams and sustained a severe contusion of the upper part of the abdomen. There was severe shock, followed by a rise of temperature to 101°. Eleven days later the abdomen was aspirated and six quarts of yellowish-green fluid removed. A diagnosis of rupture of the gall-bladder was made. Operation was deferred by the family till the twentieth day. The abdomen meanwhile was tapped twice, removing each time four quarts of bile-stained fluid. The usual incision for exposing the gall-bladder was used, but no rupture of that organ or the liver-structure could be found. After a most careful search a slit in the common duct was discovered, the wound being revealed principally by air pumped into the gall-bladder by means of an aspirating needle and a bulb syringe, the effect of which was to cause bubbles to rise up from the region of the foramen of Winslow.

On account of the numerous adhesions and the difficulty of reaching the bile-duct, no attempt was made at suture. The general abdominal cavity was excluded by a plain gauze pack, and a drainage-tube inserted down to the point from which the bile oozed up. The wound healed slowly, and the sinus closed in two or three months. The patient has gained in flesh, is perfectly well, and seems none the worse for his experience.—*Annals of Surgery*, February, 1900.

Gustave A. Van Lennep, M.D.

APPENDICITIS.—Richardson (Boston) submits the following questions:

"I. Should every case be operated upon as soon as the diagnosis is made?"

As a rule, the appendix should be removed if the diagnosis is made in the first hours of the attack.

After the early hours operation is advisable: 1. If the symptoms are severe, and especially if they are increasing in severity. 2. If the symptoms, after a marked improvement, recur. 3. If the symptoms, though moderate, do not improve.

The wisdom of the operation is questionable: 1. In severe cases in which an extensive peritonitis is successfully localized and the patient is improving. 2. In cases which are at a critical stage, and which cannot successfully undergo the slightest shock.

"II. Should the appendix be removed in every case?"

It should not be removed: 1. In localized abscesses with firm walls. 2. When the patient's strength does not permit prolonged search.

It should be removed whenever the peritoneal cavity is opened, unless the patient's condition forbids.

The appendix should be removed in all cases as soon as the inflammatory process has had time to completely subside—in from two to three months after the attack. In cases simply drained, the scar tissue should be excised, the appendix removed, and the wound securely sutured.

The author further states that, as a rule, operation is advisable as soon as the diagnosis is made in the severe cases of acute appendicitis which are attended by the initial symptoms of peritoneal invasion—in other words, those seen in the early hours of the attack. Furthermore, this exploration is demanded under the conditions of peritoneal infections described above, even if the diagnosis of appendicitis is not made, because these symptoms demand intervention of themselves, whether an exact diagnosis is made or not.

On the other hand, it seems questionable whether one should open the abdomen at the outset of an appendicitis of mild type, even if the diagnosis is reasonably clear; first, because the disease is often so mild that intervention is justified only on the ground that a trivial attack is likely to become suddenly severe, which is improbable. If operated, practically all these cases recover, but the lesion is not grave enough to justify abdominal section until repeated recurrences demonstrate invalidism.

In doubtful cases an unnecessary operation may be avoided by a blood-count made at this time.

From 100 cases of appendicitis so examined, the author draws the following conclusions:

1. Leucocytosis may be considered to be a fairly constant symptom of appendicitis.

2. The presence or absence of leucocytosis, or the degree of leucocytosis, without other data, is not sufficient to determine the local condition of the appendix and its surroundings.

3. In a series of cases the degree of leucocytosis corresponds roughly with the degree of temperature, but in individual cases great variations are found.

4. The degree of leucocytosis, when considered in connection with the duration of the attack, is of considerable assistance in the diagnosis of the local conditions.

5. A high leucocytosis (above 20,000) on the first or second day of disease suggests general peritonitis.

6. A low blood-count (below 10,000) after the first week, if accompanied by severe symptoms, indicates general peritonitis, and is of grave prognostic significance; but if accompanied by mild symptoms denotes a mild catarrhal process or walled-off abscess which has become subacute in character.

7. A high leucocytosis (above 20,000) after the first week or ten days may be taken to indicate a local abscess.

"II. Should the appendix be removed in every case?"

Removal of the appendix is contra-indicated, in the author's opinion, when there exists an abscess that can be drained through a small incision in the abdominal wall. Exceptions are, when the abscess is one-sided, when the strength is good, and when the general peritoneal cavity can be well isolated. If the appendix is not removed, an abscess being simply drained, then after recovery has taken place, unless there is good reason to believe that the appendix has entirely sloughed away, the operation of appendectomy should be completed.

The author reports 579 operations, with a mortality of 12.6 per cent. Of these, 331 were acute operations, mortality 21.7 per cent.; the remainder, 238, were interval operations with no mortality.—*The American Journal of the Medical Sciences*, December, 1899.

Gustave A. Van Lennep, M.D.

TREATMENT OF THE ABDOMINAL INCISION—(Da Costa).—I sponge off the whole raw surface with alcohol as each layer is closed. I am not at all afraid to use alcohol on the peritonæum, and in using it in this way I have a clean wound, a dry wound and an aseptic wound. A good way to stop oozing hæmorrhage deep down in the pelvis, when packing does not control it and a suture cannot be inserted, is to take a sponge, dip it in alcohol, squeeze it out, and put it in the pelvis. It will keep the wound dry, clean and antiseptic.—*American Journal of Obstetrics and Gynecology*, January, 1899.

CELLULOID YARN—A NEW MATERIAL FOR SUTURES AND LIGATURES.—

Pagestecher recommends a new material for sutures and ligatures. Acting upon the suggestion of Linhart, Trendelenburg and Lawson Tait, he has made use of linen yarn with this modification. In order to overcome the disadvantages entailed by its rough surface, its capacity of absorption and consequent increase of bulk, and the inclination of the different threads to get entangled, he impregnated it with a solution of celluloid. It was found that by this treatment the yarn acquires great firmness and resistance, the surface is smooth and brilliant, and its tendency to absorb pus or other secretions from wounds has completely ceased. The thread will not unravel and expand, and as the strength is materially increased by the celluloid, and is much greater than that of silk, much finer threads can be used without fear of their breaking.

The material is easily sterilized, not being in any way affected by steaming vapor or boiling, and will stand any number of sterilizations. The author has made use of this material exclusively for ligatures and sutures, has used it on the bowels, the bladder and within joints, and expresses himself as extremely well gratified with the results. The yarn is much cheaper than either catgut or silk, can be obtained already prepared and put in suitable packages for use by the surgeon or general practitioner, or may be secured in bulk for hospital purposes. — *The Philadelphia Medical Journal*, February, 1900.

Gustave A. Van Lennep, M.D.

AN EXPERIMENTAL RESEARCH ON THE TENSILE STRENGTH OF THE SCIATIC NERVE.—Crile and Lower (Cleveland) publish a series of experiments undertaken to ascertain the tensile strength of the sciatic nerve under the same conditions as would exist during the operation of nerve stretching. There were nine experiments on human bodies, done as soon after death as possible. The nerve was exposed, and by means of an apparatus which allowed the force to act at right angles to the thigh, weights were rapidly applied till the nerve ruptured. With one exception, the subjects were adults, and the average weight required to break the nerve was one hundred and forty pounds and three quarters. On an average it may be said that a loop of the great sciatic would bear, for a short time, nearly the entire weight of the body. Out of fourteen cases, six broke at or near the point where the hook was applied. Of the remaining eight cases, the nerve itself did not break, but its connection with the spinal cord and its membranes were detached. The dura mater was torn near the point where it is prolonged from the main sheath on to each nerve.

There were also seventy-two experiments on dogs; which showed the following: Total weight of animals, 1,786½ pounds; total of sciatic tensile strength, 2,507 pounds; average ratio of weight of dog to tensile strength is as 3 to 4. — *New York Medical Journal*, February, 1900.

Gustave A. Van Lennep, M.D.

THE TECHNIQUE OF BASSINI'S OPERATION AS PERFORMED BY HIMSELF —(Andrews).—The skin and fat are drawn up in a fold 7 to 10 cm. high transverse to Poupart's ligament, and quickly incised between the operator's and assistant's hands, making an incision 12 to 18 cm. long and 3 or 4 cm. above Poupart's ligament. The aponeurosis of the external oblique is laid bare at a single stroke, and the pillars of the ring exposed. The dissection of the

external oblique is quickly made with the handle of the scalpel until Poupart's ligament is exposed on its inner aspect. The cord mass is now raised by blunt dissection, and any loose lobules of fat stripped up as high as possible. The isolating of the sac is usually begun at the neck. It is stripped from the cord, and the neck of the sack is detached from the internal ring by loosening the peritonæum for 2 cm. all around it. The sac is now widely opened at its fundus and its whole interior inspected. Adherent masses of omentum are returned after careful hæmostasis, and only removed when they are much thickened and hardened, as in certain old hernias. If no adhesions are found, a clamp is at once placed as high up as possible on the neck of the sac. The sac is removed by tying a strong silk ligature around its neck above the clamp, and in large sacs the ends of the ligature are passed through the stump and tied around the first loop. The sac is now cut off just outside the clamp and the latter removed. The elastic peritonæum draws the stump well inside the peritonæum, and, of course, the remainder of the operation is outside the peritonæum.

The dissection of the peritonæum away from the internal ring has also the effect of loosening the transversalis fascia and internal oblique muscle, so that the margins of the ring are free and even undermined, and are the structures in the Bassini operation to be included in the first or deep line of suture, intended to restore the enlarged ring to its normal size. A forceps, pointing from the internal ring inward, is made to grasp the transversalis and internal oblique, *i.e.*, the blades grasp the whole of the posterior wall except the peritonæum. This gives a ready means of handling and raising the structures in placing the deep stitches. A flat director is sometimes used at this stage, and thrust into the internal ring to push forward the posterior wall and to steady it as the needle enters its substance, and enables the operator to pick up the transversalis fascia without risk of puncturing the peritoneal cavity.

The insertion of this deep suture is the essential and important feature of the operation. The bottom of the wound is clearly exposed, and the cord is held outside the canal by a loop of silk clamped with an artery forceps to the gauze covering the abdomen.

The deep stitches are placed beginning very close to the pubic bone. The first one or two may in some cases include part of the rectus muscle and sheath. Each stitch enters the transversalis and internal oblique 1.5 cm. from their lower margin and makes exit at that margin. The needle then penetrates the shelving edge of Poupart's ligament from within outward. From four to six such stitches are placed behind the cord, the last one narrowing the internal ring until it fits tightly around the cord and forceps blade. The order of tying these stitches is the opposite of their insertion. The upper one—that nearest the cord—is first adjusted, and the others follow downward in succession. The distance between these stitches is considerable—1.5 or 2 cm. Their effect is not only to restore the length and obliquity of the canal, but to invert the upper or muscular segment like a Lembert suture, and to draw it somewhat behind the ligament, and not merely against it, which gives broad surfaces of union.

The cord being replaced in the repaired canal, the second suture—that reuniting the external oblique aponeurosis—is placed as follows: The outer angle is lifted on a blunt hook, and two silk stitches are placed here and tied.

A running or continuous suture is then rapidly inserted until the pillars of the external ring are reached. Here one or two separate stitches are now placed to bring it to the proper size. This form of suture is rapid, and gives abundant tension at the two ends without danger of puckering or shortening the incision. All the arteries are now tied with silk, and the skin is closed by a continuous button-hole stitch. Drainage is seldom employed. The only dressing is moist sublimate gauze covered by large masses of sublimate cotton enveloping the hips, thighs and abdomen, front and back, and the whole enveloped in wet starch-and-lime bandages from the middle of the thighs to the middle of the abdomen. This dressing and the skin suture are removed on the eighth day. A light gauze dressing is applied, and the patient is at once allowed to leave his bed and go home, with the advice to remove the dressing in a few days. There are probably less than 5 per cent. of recurrences after two or three years. No truss or support is ever used, and no limit to exercise is enjoined. The question of recurrence is bound up with that of stitch-abscess. Primary union is essential to success. Sepsis prevents this union, as in all plastic work.—*Medical Record*, October 28, 1899.

George R. Southwick, M.D.

THE INDUCTION OF PREMATURE LABOR—(Bollenhagen).—The writer describes an excellent method of performing this operation which seems free from some of the dangers of the other methods. The best time for the operation is the thirty-sixth week, as near as it can be determined, unless before this the child has grown large for the pelvis. The genital tract is very thoroughly cleansed and made as aseptic as possible. The cervix is then drawn down and the canal wiped out with sublimate. The canal is then tamponed with two or three strips of iodoform gauze saturated with a few grammes of sterile glycerin. The vagina is then loosely filled with iodoform gauze. This dilates the cervical canal and prepares the way for the introduction of some form of colpeurynter for further dilatation. In some cases the latter is not necessary. Ten children were saved in fifteen cases, and it is interesting to add that these same women had had thirty-six labors, and only six children born alive, which illustrates the advantages of the operation.—*Zeitschrift für Geburtshilfe und Gynäkologie*, vol. xli., H. 3, 1899.

George R. Southwick, M.D.

• URETERAL ANASTOMOSIS—(Noble).—The writer describes three methods of performing this operation. Van Hook's method, which consists in ligating the bladder end and invaginating the kidney end into the distal portion just beyond the ligature. It is carefully sutured in this place and buried extra-peritoneally. The ends of the ureter may be cut squarely and joined end to end, but there is less danger of stricture and contraction if the ends are trimmed obliquely to match each other and then united as recommended by Bové. The writer splits up a little the cut end of the distal portion, and removes as much of the mucous membrane as can be drawn out, which leaves the outer part of the ureter as a cuff, into which the proximal cut end is invaginated and secured by mattress sutures. A small bougie passed into both cut ends, down into the bladder and out of the urethra, to facilitate removal, makes it much easier to perform the operation and to maintain the calibre of the ureter. Transplantation of the ureter into the bladder is to be practiced if it is divided near enough for it to be accomplished without too much trac-

tion on the cut ends. No one method of repair is suited to all cases.—*The American Gynecological and Obstetrical Journal*, August, 1899.

George R. Southwick, M.D.

THE TREATMENT OF LACERATIONS OF THE CERVIX AFTER DELIVERY—(Cushing).—The writer states that, after carefully douching out the vagina and afterwards drying it as perfectly as possible, the vagina is filled, by means of a teaspoon, with a preparation that has been a great comfort to his patients and of immense satisfaction to himself. To each ounce of freshly and properly made oxide of zinc ointment are added a grain of morphine and a grain of cocaine. The vagina is filled with this mixture, and a large teaspoonful is also introduced into the rectum, which usually suffers more or less in the process of childbirth. The presence of the ointment in the vagina, slightly astringent and soothing, favors healing by first intention, and no vaginal injection is permitted and no manipulations are required. The gradual oozing of the ointment keeps the repaired perinæum protected, and prevents any urine from entering the vagina or contaminating the wound. (The free use of the ointment, as suggested by the writer, needs some care to guard against an excessive dose of morphia.)—*American Journal of Obstetrics*, November, 1899.

George R. Southwick, M.D.

INERTIA AND SUB-INVOLUTION—(Stover).—The writer recommends the frequent observation of cases of abortion for several weeks following the puerperium, owing to the frequent occurrence of sub-involution in these cases. The daily use of the slowest interrupted faradic current for fifteen minutes is of the greatest benefit to such cases of sub-involution as are marked by faulty physiological action. There is no hyperplasia. There is passive and less often active hyperæmia and stasis. The effects of the faradic current are analogous to ergot, but they are more prompt and energetic. It produces a sort of interstitial massage, increases the activity of the circulation, accelerates absorptive processes, and improves nutrition. The hot-water douche, at a temperature of 115° F., with a continuous flow for fifteen minutes, and the elevation of the hips meantime, is also recommended, together with an hour's rest in a recumbent position afterwards. He has also been well satisfied with Tait's treatment of such cases with ergot and the citrate of potash. The latter should be given in doses of from one-half to one drachm three or four times a day, preferably administered an hour before meal-time with half a pint of water.—*American Journal of Obstetrics*, November, 1899.

George R. Southwick, M.D.

THE AFTER-TREATMENT OF ABDOMINAL SECTION—(Robb).—He washes out the abdominal cavity after every abdominal section with sterilized salt solution, and leaves 300 to 500 c.c. in the abdominal cavity. The patient is then kept with the head low for twenty-four hours, as advised by Clark. The patient receives, on being put to bed after the operation, an enema of one ounce of black coffee, and this is repeated every hour. Every three hours afterwards a nutritive enema is given, consisting of twenty grains of common table salt, the whites of two eggs, and one ounce each of whiskey and peptonized milk. He does not use morphia or any of its derivatives as a routine measure after abdominal operations. As a rule the bowels were opened on the second day, usually by giving two grains of calomel, and eight hours later a high injection of two ounces of glycerin, followed in two hours by another injection of one pint of warm soapsuds.—*American Journal of Obstetrics*.

George R. Southwick, M.D.

TUBERCULOSIS OF THE CONJUNCTIVA.—Dr. T. L. Henderson reports a case of tubercular ulcer of the conjunctiva which is of interest, because an early microscopical examination of the ulcer might have revealed the existing constitutional condition before the physical signs pointed to it, and possibly before the disease had reached the incurable stage. The patient, a woman 56 years of age, had been treated for an obstinate ulcer upon the palpebral conjunctiva, but had shown no constitutional symptoms other than a slight daily rise of temperature, supposed to be malarial. Dr. Henderson curetted the ulcer, with the result of healing it in about a week. The woman, however, died of pulmonary tuberculosis five months after the operation on the lid.

The microscope proved the ulcer to contain giant cells, tubercles and tubercle bacilli. Bacilli were also found in the patient's sputum.—*The American Journal of Ophthalmology.*

Wm. Spencer, M.D.

OTITIS MEDIA AND EARACHE IN LOBAR PNEUMONIA OF CHILDREN.—The author has observed a sufficient number of cases of lobar pneumonia in children at the beginning of which earache was a first and predominant symptom to make him think there is some casual relation between the two. He reports a number of cases as evidence of this, but in none of them did the earache terminate in suppuration. He thinks the pneumococcus may be the cause, as it has been found in the discharges from suppurative ears, or that possibly the earache is only a sympathetic pain of the chronically inflamed drum, since the initial earache nearly always occurred in ears which at some time or other had been the seat of an inflammation.—J. S. Meltzer, *Phila. Med. Jour.*

Wm. Spencer, M.D.

THE OPHTHALMOSCOPIC CONDITION IN A CASE OF PNEUMONIA.—The author describes interesting changes in the fundi of a young man who was suffering with pneumonia.

From the commencement of the attack the patient had noticed an increasing disturbance in his vision. A small central part of the field remained clear, but all around this area there was marked indistinctness. Ophthalmoscopic examination showed in both eyes five or six round white specks about one-half the diameter of the pupil, and located right around the macula. Two of these white dots were noticeably elevated.

The patient recovered, and six weeks later, when another examination was made, the fundi were found to be normal, though the visual indistinctness persisted for a year. Axenfeld and Goh have made similar observations in cases of pneumonia.—Dr. Chemnitz, Fraenkel, *Archiv. für Ophthal.*, Bd. xlviii., Ab. 2.

Wm. Spencer, M.D.

PROTARGOL.—In a series of 100 cases Engelmann used a 20 per cent. solution of protargol, which proved to be less irritating and to be a better bactericide than argentic nitrate. According to Cramer, in his series of 100 cases treated with argentic nitrate, 96 showed more or less secretion, sometimes even to the fifth day. In Engelmann's series 80 per cent. showed no, or very little, irritation, which lasted at the most one and a half days. There was no secondary catarrh.—*Annals of Ophthal.*

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE THERAPEUTICS OF SABAL SERRULATA.—In a communication to the British Homœopathic Society, Madden reviews Hale's monograph on saw-palmetto, and states that his own experience with the drug is as yet very limited. He has, however, cured one bad case of nocturnal enuresis in a boy of 13, though he has utterly failed to cure two other boys and one girl on whom he tried it. The dose used was two or three drops of the 1x, three times a day. He is inclined to expect that this drug is one which will act with varying intensity on different patients. A drug which has such a very decided selective affinity to the generative and urinary organs of both male and female provers, and can produce such pronounced effects upon them, of a kind that are constantly being met with as the result of disease, ought to prove of great value to those who make use of the homœopathic law of drug selection.

In the ensuing discussion the President of the Society, Dr. Epps, mentioned two cases, one of prostatic trouble and one of bladder irritability, in which the drug had acted well.

Dr. Dudgeon had used sanmetto, sabal serrulata combined with sandal oil, for prostatic disease without effect. He had prescribed sabal serrulata in two cases of enlarged prostate. One patient, a man nearly eighty years of age, was relieved of bladder irritability and prostatic symptoms generally. The second case did not report.

Dr. Sandberg gave the drug in five-drop doses of the mother tincture to an old gentleman who had suffered from enlarged prostate and chronic cystitis for many years. As the result of an acute attack he was unable to pass water, and it was necessary to use a catheter almost every hour. After a month's use of sabal, the intervals had increased to three or four hours, and the improvement continued for the three remaining years of his life.

Dr. Dudley Wright cautioned his hearers against disappointment should they use the drug indiscriminately for patients suffering from enlarged prostate. He had made extended use of the remedy, and had endeavored to find its exact sphere of action, especially with a view to differentiating it from the other drug so extremely valuable in prostatic cases, viz., picric acid. He concluded that its action was upon the generative organs, the testicle, prostate, bladder and membrano-prostatic urethra, partly through the vascular system and partly through the nervous. Its action on the bladder was a direct one, due to the excretion of the drug by the kidneys. Contrasting it with picric acid, it had nothing to compare with the enormous excitement caused by picric acid through its action on the lumbar cord. Despondent patients were relieved by sabal, irritable ones improved under picric acid. The tincture should be prepared from the fresh berries.

Dr. Hughes' experience with sabal had been negative as to good results. Dr. Green thought it rather anomalous that the manufacturers who were pushing sabal serrulata had found it necessary to put a little sandal oil in the preparation in order to make it efficacious. He was inclined to think its success was due to the oil. Sabal having been strongly recommended in chronic bronchitis with profuse expectoration, he had tried the drug in one case with fair results; the secretion was lessened, and fetid odor could hardly be detected. Dr. McNish had used the drug in many cases without satisfactory results. He had found other drugs like sandal oil much more efficacious in cases of enlarged prostate.—*Journal of the Brit. Hom. Society*, Jan., 1900.

F. Mortimer Lawrence, M.D.

THE SNAKE POISONS AS HEART REMEDIES.—Halbert states that naja and lachesis are remedies which physiologically affect the pneumogastric, and thereby depress the cardiac action. Hence they are used dynamically in cases of great cardiac depression when there is palpitation, with a slow, weak pulse. The same may be said of erotulus, inasmuch as it represents adynamic conditions affecting the heart.—*Clinique*, Dec. 15, 1899.

F. Mortimer Lawrence, M.D.

VALERIANATE OF AMMONIA IN FUNCTIONAL CARDIAC NEUROSES.—According to Halbert, valerianate of ammonia in the second or third attenuations is one of our most useful remedies in cardiac complications of functional and neurotic origin. In the erratic actions of the heart associated with hysteria or neurasthenia it will bring about perfect functional activity. It will even overcome pain in such conditions, and suppress neuralgic crises which are purely dependent on nervous perversions. It is also indicated in cases of exhaustion from excessive mental strain when the heart becomes irritable and weak. With this we associate ignatia, nux vomica, valerianate of zinc, coffea and hyoseyamus.—*Clinique*, Dec. 15, 1899.

F. Mortimer Lawrence, M.D.

THE VALUE OF CACTUS GRAND. AS A HEART REMEDY.—According to Halbert, the efficacy of cactus is still questioned by many. It is most useful in extreme organic conditions when a "heart-tonic" seems necessary; even then it is most effective in the minute dose repeated frequently. The principal symptom refers to a peculiar constriction in which cardiac palpitation is generally attended by symptoms of lung engorgement; the feeling is as if an iron hand compressed the chest, and it is peculiarly associated with asthmatic attacks, in which the patient is relieved by coughing. Pain is an attendant symptom. Cactus has not sustained the reputation it held for a long time as a safe cardiac stimulant, and hence it is not used as frequently as in the past.—*Clinique*, Dec. 15, 1899.

F. Mortimer Lawrence, M.D.

THE USE OF AGARICIN AS A HEART TONIC.—In reviewing the heart tonics Halbert, of Chicago, states that agaricin is advised by Goodno in cases of dilatation associated with emphysema of the lungs. It relates to the heart feebleness incident to infectious diseases. The first decimal trituration is generally used. When chorea complicates the cardiac condition, as we frequently observe in young adults, it is always indicated. Then, too, it is valuable in disturbances of the alimentary canal, which are often defined as nervous dyspepsia. Nausea and loss of appetite are constant symptoms.—*Clinique*, December 15, 1899.

F. Mortimer Lawrence, M.D.

LILIUM TIGRINUM IN HEART DISEASES.—According to Halbert this remedy, though rarely thought of in cardiac disorders, is very useful when the symptoms are associated with reflex uterine disturbances. It therefore has a greater affinity in its action for the female. Palpitation, attended by faintness, is its chief symptom, and this invariably comes from uterine disturbance. A peculiar sense of suffocation or constriction, coming on from reflex causes, is promptly relieved by this remedy.—*Clinique*, December 15, 1899.

F. Mortimer Lawrence, M.D.

THE SYMPTOMATIC USE OF DIGITALIS.—According to Halbert, of Chicago, digitalis, given as a symptomatic remedy in accordance with the homœopathic principle, is most efficacious. First of all, it has gastric disturbance associated with the cardiac perversion, hence nausea and vomiting are present. The cold surfaces resemble the symptoms of camphor. The pulse is slow and irregular, showing cardiac arrhythmia; the cardiac action is increased by exertion, but the tension is diminished. There is always a feeling of precordial constriction, with a sense of anxiety. Cyanosis is generally present; suffocation and dyspnoea attend the extreme cases. Digitalis is also a remedy which corrects the perversions of the liver, when they are associated with cardiac involvement.—*Clinique*, December 15, 1899.

F. Mortimer Lawrence, M.D.

THE MEDICAL TREATMENT OF MALIGNANT AND OTHER OBSTRUCTIVE AFFECTIONS OF THE STOMACH.—Dyce Brown, after summarizing the possible causes of obstruction, considers the therapeutic possibilities in each division:

1. Cancer, from the homœopathic standpoint, is incurable. The treatment is mere palliation. If pain is prominent, such medicines as gelsemium, arsenic, hydrastis and conium, and ultimately opiates, are indicated. If vomiting is troublesome, arsenic, ipecac, apomorphia, hydrastis and nuxvomica are useful, according to their indications.

2. In cicatricial obstruction, produced by ulcer close to the pyloric orifice, or as the result of swallowing a corrosive acid, the therapeutics are again symptomatic, and, as in cancer, careful diluting is necessary.

3. The cases of fibroid thickening of the coats of the stomach, together with which may be classed chronic gastritis, require regulation of diet and the medicines used by homœopaths to cure chronic thickening of mucous membrane caused by catarrh in other situations. These include arsenic, hydrastis, antimonium tartaricum and crudum, nuxvomica, pulsatilla, and also sulphur, calcarea and silica. These cases require long and continuous treatment, but they hold out every chance of marked improvement.—*Journal Brit. Hom. Society*, January, 1900.

F. Mortimer Lawrence, M.D.

STIGMATA MAIDIS IN INTERSTITIAL NEPHRITIS.—In the course of an article upon prostatic hypertrophy, Wright, of London, mentions that in cases where the kidneys are affected with interstitial inflammation and there is diminished excretion of urine, corn silk (*stigmata maidis*) is a useful drug. It is necessary to use a preparation from the fresh plant, as the mazineic acid, upon the presence of which its efficacy largely depends, undergoes fermentation within twenty-four hours of cutting the plant.—*Monthly Hom. Review*, February 1, 1900.

F. Mortimer Lawrence, M.D.

CLINICAL HINTS.—Dr. J. Evans, on account of the favorable influence which the yellow iodide of mercury exercises in syphilis of the liver, prefers this salt of mercury in amyloid degeneration of that organ, which he claims he has seen to affect favorably.

Jaborandi is frequently indicated in *migraine*, when the eye muscles are at fault.

Verbena hastata is one of the best remedies in epilepsy.

Cantharis in acute pleurisy is often a better remedy than *bryonia*.

Camphora is a good hypnotic in neurasthenia, when there is a tendency to spasms or hysteric contractions.

Opium has cured a case of cerebral pneumonia in Dr. Pierron's hands.

Arsenicum is of service in neuralgia with a tendency to swelling of the affected part.

Bryonia is indicated in headache ameliorated by pressure.

Baryta iodata (3x), one powder a day, rapidly cured an infant dying of inanition.

Iodium is said to be of service in the night-sweats of consumptives.—

Journal Belge d'Homœopathie, vol. iv., 1899.

Frank H. Pritchard, M.D.

TREATMENT OF THE GRIPPE.—Dr. Leon Simon, in the epidemic form recommends at the beginning aconite; eupator. perfol. when there are contusive pains in the limbs, small of the back, and neck; in these cases *rhus tox.* and *bryonia* are also useful. In the catarrhal form *bry.*, *ipecac.*, *merc. sol.* and *hepar s. c.* are of value; in the pneumonic form variety *bry.*, *phos.*, *tart. emet.*, *ars.*, *ant. sulph. auratum*; in the pleuritic form *bry.*, *sulph.*, *canth.*, are indicated; in the intermittent variety the first triturations of *chininum sulph.* and *ars.* are to be administered; in the choleric form *veratr. ars.*, *merc. sol.* and *china* will be of service; in the syncopal form the tincture of aconite and *ars. album* he has found useful. In the comatose variety *opium 6x* he has employed with good results, while in the albuminuric form he can recommend *apis*, *ars.*, and *cantharis*.—*Ibidem*.

Frank H. Pritchard, M.D.

TREATMENT OF FLATULENCY.—Dr. Stoneham, in flatulency, regards as the best remedies:

Carbo Vegetabilis.—Great distention and sense of fullness; the stomach feels distressed and heavy, and so tympanitic that it seems as if it would burst. The flatulence appears to be equally distributed through the stomach and bowels, and the patient passes a great deal of gas both by the mouth and anus, without effort, but also without relief. The gas, however, does not give rise to colic.

China.—The distention of the stomach is accompanied by eructations of a bitter fluid or regurgitation of food, which do not relieve. The sense of bloatedness is ameliorated by movement (the contrary of *bryonia*). *China* is particularly indicated in cases from abuse of tea, and generally there is colic at night. It also will be found useful in those with nervous prostration.

Argentum Nitricum.—Flatulence limited to the stomach, with eructations after meals, but with difficulty; with a feeling as though the gas passed the cardiac orifice with difficulty. When this is overcome, it escapes with violence and in great abundance.

Bryonia.—Great distention and sensitiveness of the abdomen, and particularly in its upper portion. Pinching pains, which hinder breathing. The least movement aggravates; hiccough and eructations immediately after eating, which give relief.

Lycopodium.—But little flatulence in the stomach, but, on the contrary, a great abundance of gas in the intestines, and especially in the colon. It becomes incarcerated and presses upwards towards the diaphragm. The patient complains of a sensation as though a cord were compressing the waist, and a disturbing sense of pressure downwards upon the rectum and bladder. The gas rattles and rolls about in the bowels, and there is colic, which is accompanied by emission of flatulence by the rectum. It is one of our best remedies in intestinal dyspepsia.

Nux Vomica.—The epigastrium is bloated up, but at the latest up to two or three hours after meals, and the patient complains of a feeling as if a stone were lying there, with pressure beneath the false ribs. At the same time there is colicky pain and false urging to stool. There is more colic and less distention than in lycopodium, which it much resembles.—*L'Art Medical*, No. 9, 1899.

Frank H. Pritchard, M.D.

KALI NITRICUM IN TURBIDITY OF THE CORPUS VITREUM.—Dr. E. Karcher observed a man of 58, a painter on glass, who suddenly noticed that his vision became clouded; an eye-specialist diagnosed a turbidity or a hæmorrhage into the vitreous body. Kali nitricum 3x, ter die, in three months caused the effusion wholly to be absorbed. Other remedies are arn., ham., kali iod., solanum nigr., bell., cimicifuga, mercur., phos. and sulphur.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 19–20, 1899.

Frank H. Pritchard, M.D.

COLCHICUM IN RHEUMATISM.—Dr. Mossa cites Kafka as to the value of colchicum in acute articular rheumatism, especially where the patient is very sensitive, so that the slightest jar of the bed, air or floor renders the pains unbearable. The fever and pains exacerbate during the hours of the evening and night, with copious sweats and excretion of a scanty and thick urine, together with insatiable thirst. The larger joints are intensely red and hot, while the smaller ones appear swollen and stiff, and even while they are most painful they feel as if paralyzed or numb. At the same time, in consequence of the fever, the respiration is much accelerated and the heart impulse is greatly augmented, so that a possible complication of endocarditis or pericarditis is to be feared. In such a case colchicum (3) acts much better than aconite or bell., for within twenty-four hours the most violent pains may be alleviated and the disease under control. Under such circumstances one should frequently examine the thorax, for he has not seen good results from this drug in endocarditis nor pericarditis, but rather then give spigelia.

Colchicum has a special affinity for fibrous tissues, including the tendons and aponeuroses of the muscles, the ligaments, and even the periosteum. The swelling caused by colchicum may be dark red or even pale, and very sensitive to pressure and movement, with a great inclination to jump from one joint to the other. The evening and night aggravations are markedly pronounced. In chronic cases there is weakness from lack of sleep. Every slight external irritation, as of light, noise, or strong odors, distress them, and their pains seem to them unbearable. The patient may suffer from violent cramps of the muscles of the feet, and particularly of the soles of the feet.

With the acute rheumatic symptoms there are violent cutting and piercing pains in the chest, especially in the region of the heart, with great oppression and difficult breathing—indications of value in rheumatic affections of the chest and heart.—*Allgemeine Homöopathische Zeitung*, Nos. 15 and 16, 1899. Goodno—*Practice of Medicine*, vol. ii., p. 871—regards colchicine as nearly as specific for articular rheumatism as quinine is for intermittent malarial fever. He employs one grain of Merk's preparation to one ounce of alcohol; and, like many other remedies, it often acts best when given almost to the point of physiological action, the indication of which is some disturbance of the gastro-intestinal tract (nausea, colic, loose movements). This action may be avoided if discontinued for a short time, and then resumed in one-half to two-thirds of its previous dose after complete disappearance of its annoying symptoms. If skilfully employed, the pain and swelling quickly diminish, and the most active cases are usually controlled within a few days. A little experience with this remedy is necessary before one learns to administer it to the greatest advantage. It is necessary to continue the general care of the patient and the medicine for at least ten days, or the symptoms may return. This statement applies equally to any method of treatment. Of the preparation of colchicine, doses of three to five drops, repeated every two to four hours, according to the age of the patient, the intensity of the pains, etc., is the method he employs.

Frank H. Pritchard, M.D.

CHINA IN PERIODIC HEADACHES.—Dr. Berlin was consulted by a woman of 30 years who six years previously, while nursing an infant, had been seized by periodic headaches which since then had not left her. Advised by a physician to wean the child, they decreased somewhat in severity, disappeared now and then for a time, but were sure to return and to last for weeks. During the last two years they had increased decidedly in intensity, so that for four or five weeks they would not cease. When she came under treatment she had been suffering from an attack of six weeks' duration. The patient was large and robust, and though anæmic in appearance complained of none of its symptoms. Her appetite was good; her bowels and menses regular. The pain was described as stitching, boring and throbbing in the forehead, temples and vertex, as though the brain would crowd through the skull. Now and then most painful stitches would shoot across through the brain. She was extremely sensitive to noises, music, and complained of violent and paroxysmal vertigo, especially if she stooped over and then raised up. The scalp was very tender on contact, so that combing her hair was almost impossible. The headache came on promptly at nine in the forenoon, and between ten and twelve became almost intolerable, gradually to decrease from one o'clock in the afternoon, and at two it would have disappeared. China 1x was given, five drops four times a day. In three days the headache had wholly vanished. Four months afterwards she had remained free from it.—*Leipziger Populäre Zeitschrift fuer Homöopathie*, Nos. 19-20, 1899.—Such a headache would make one think it of malarial origin, although many diseases have this strange periodicity without being malarial. They seem to have a "touch of malaria" along with the other symptoms. Osler states that this peculiarity is noted in regions where there is none of this disease. "Long-lasting headaches smell of syphilis," says Ricord.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

APRIL, 1900.

THE DIAGNOSIS OF CONTRACTED KIDNEY.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

CHRONIC interstitial nephritis occupies a very broad place amongst chronic diseases, the kidneys being important depurative organs, whose work only in a slight degree can be taken up by the other excreting organs, and when they begin to fail, the health suffers. These signs are not always easily interpreted, and, being at times misleading, one may be led astray until examination of the urine, with attention to the heart and blood-vessels, throws light on the case. I consider a knowledge of chronic contracted kidney and its phenomena as of foremost importance in the practice of medicine; in fact, there is no other chronic disease which is as often met with. This may seem to be a wild assertion, yet, if one be in the habit of examining the urine, heart and arteries of patients methodically and carefully, he will be astonished how frequent it is. Again, it is, to a certain degree, physiological at an earlier or later age; for old age, with its senile and retrogressive changes, is our common lot. F. Hoffmann—*Die Altersinvolution und ihre Therapie*; *Wiener Medizinische Presse*, Nos. 26, 27, 28, 1899—in considering the laws of involution of our body, claims that these senile changes of our organs do not proceed uniformly nor harmoniously, but irregularly—now in this, now in that organ—to reach a certain limit, according to the hereditary predisposition, the way of living, and to preceding diseases.

Contracted kidney may be present for a long time without appearing to influence the health or bring about symptoms. The signs and symptoms are multiple, and, unless intercurrent nephritis intervene, may not of themselves suggest kidney disease. West—"Some Clinical Aspects of Granular Kidney," *The British Medical Journal*, Nos. 1991, 1992 and 1993, 1899—divides the symptoms into the cardio-vascular and the toxæmic, a very convenient arrangement. The former are important, because they often cause death earlier than it might otherwise occur. The toxæmic always develop, if the patient live long enough. They depend upon the wasting of the kidney, become manifest when it has reached a certain degree, and progress step by step with it. The cardio-vascular symptoms are more or less mechanical or accidental.

Cardiac Symptoms.—Heart failure is often the first symptom to cause anxiety. Thus, a little shortness of breath and palpitation on exertion, with, it may be, slight cardiac pain or some swelling of the feet, may direct attention to the heart, which is found hypertrophied or dilated, and that without obvious change in the heart itself. The symptoms are usually gradual in onset, but may come on suddenly. The pain, though usually slight, may be severe enough to be called angina. In elderly persons these symptoms might be the result of atheroma, but in middle life and in the young contracted kidney is the most frequent cause.

How many of such patients come to us with a shortness of breath, a great deal of pharyngeal and bronchial catarrh, a troublesome cough, a sort of "compensatory bronchitis," a very full and high-tension pulse, or, if compensation be failing, an irregular and weak pulse, and heart which, though dilated, seemingly has no valvular disease, and whose myocardium is still in fair condition. These cases are often diagnosed and treated as "heart cases." One may even find quite pronounced murmurs at the valvular orifices. This will be especially noted after compensation is broken and the heart-stretching does not allow the valvular segments to come together and close. Osler speaks of a valvular incompetency due to a dilatation of the heart-muscle, so that the valve-segments fail to close an enlarged orifice. These murmurs generally disappear after the heart regains its strength. If a patient be seen in this state,

it is so easy to diagnose a heart disease. Cardiac symptoms are, however, not constant, even where the heart is greatly hypertrophied or the valves diseased.

An acute pericarditis is, according to West, a very serious complication, possibly producing but few symptoms, and only to be detected by physical signs, yet the evidence of contracted kidney is generally plain enough. It may be the first sign of ill-health, and, though producing but few symptoms, it is *a sign that death is near*.

Woodbridge states contracted kidney to be the cause of aneurysm in 6 per cent. of the cases observed at St. Bartholomew's Hospital. Among the vascular symptoms are hæmorrhages and degenerations.

Hæmorrhage.—This may take place into any part of the body, but it is in the brain that its most serious effects are noted, and post-mortem statistics prove the remarkable frequency with which contracted kidney is found associated with cerebral hæmorrhage. Dickinson gives 41 and Pye-Smith 75 per cent. of apoplexies as due to granular kidney. We all recall the heavy and full pulse of apoplexy. Now this is not all due to irritation of certain nerve-centres, for these subjects will be found to have a high-tension pulse long before the seizure occurs. In elderly persons due allowance may be made for atheroma, but even elderly persons may have granular kidney and a little atheroma, while in middle life contracted kidney is the usual cause; and in the young it may explain cerebral hæmorrhage, which would otherwise present great difficulty. Thus, in Woodbridge's cases there was one at 19, one at 27, one at 30 and two at 37. O. Heubner—*Die Chronische Nephritis im Kindesalter*, an excellent little work—also points out this cause in these obscure cases.

West mentions the case of a young man of 21 who was affected with left hemiplegia, which came on in the midst of apparent health and was evidently due to hæmorrhage, where no cause could be detected until the thickened radial and high arterial tension suggested granular kidney. Albumin was found in his urine.

Preceding infectious diseases may be the causes of dormant and unobserved renal disease, leading to granular kidney in

children. The necropsy in an apoplectic subject may reveal the brain ploughed up by a hæmorrhage of the common kind; or at times, instead, one may find small hæmorrhages which may give rise to the occasional unilateral fits of uræmia, a small hæmorrhage into the medulla, a nuclear paralysis of special nerves, or pontine hæmorrhage.

Epistaxis may be the first symptom of the disease, and even in the young contracted kidney should not be forgotten as a possible cause of repeated nose-bleed. It is a common symptom in this form of kidney disease, and to be expected from the increased blood-tension.

Hæmaturia was not recognized as a result of contracted kidney until West published some cases a few years ago. The blood is intimately mixed with the urine and is bright in color, and for this reason West is inclined to believe that it has its origin in the bladder; at any rate, except when granular kidney is associated with acute intercurrent nephritis, and but rarely then, is the urine smoky or dark in color. In a case recently reported by him the cystoscope revealed the blood passing by the ureters. It may be so red and bright as to look like pure blood, but even then there are hardly ever any clots. This form of hæmaturia, he asserts, has led to frequent mistakes, as, for example, to the diagnosis of stone in the bladder, for which operation has been suggested and performed. The hæmorrhage is not often copious, but in slight amount it is frequent, common and recurrent. To this recurrent hæmaturia experience has led him to attach considerable diagnostic value.

West has noted one case of hæmatemesis; he knows of one of hæmorrhage from the bowels. He has never met with a case of hæmoptysis.

About a year ago I lost a patient with contracted kidney from a fulminant bronchial hæmorrhage which destroyed life in a few minutes, flooding the whole bronchial tree. Contracted kidney had been diagnosed by myself and a neighboring practitioner, who is an excellent diagnostician and a man of vast experience. The age, high arterial tension, arteriosclerotic changes, urine of low specific gravity, casts and albumin in the urine, with a persistent cough and general loss of flesh and strength, certainly supported our diagnosis. I had seen her during the preceding afternoon at my office, when she was sprightly, said she felt fairly well, and better than for

days. That night she was seized with a coughing-fit, bled profusely from the mouth, and when I arrived she lay dead, with her mouth open and the clotted blood up even with her lips. No necropsy.

West also refers to persistent hæmorrhages from the uterus which have required full doses of ergot to control. I know of such a case in a young girl of 17 with contracted kidney, where profuse menstruation first called attention to something being abnormal. Examination revealed the clinical signs and symptoms of a granular kidney, from which she still suffers.

In the last stages of contracted kidney West is authority for the statement that the patient may pass into an almost hæmophilic condition, in which slight though continuous and almost uncontrollable oozing takes place from the various parts of the body—from the gums, nose, tongue, lips, vagina, or from any wound or scratch in the skin. A considerable amount of blood may thus be lost, and the anæmia from which the patient is already suffering be greatly aggravated.

Years ago Gull and Sutton drew attention to the degenerative changes which result from arterial disease in contracted kidney. Bond has called to our notice the remarkable frequency of granular kidney in post-mortem examinations of the insane in an asylum, and has shown that it is nearly double that in a general hospital; and he rightly concludes that there must be a close relation between the two diseases. Some nervous diseases associated with granular kidney may be of toxic as well as of arterial origin.

The mental disturbances of this disease are very interesting, and at times misleading. Toulouse has studied them thoroughly—"Les Troubles Méntaux de l'Urémie," *Gazette des Hôpitaux*, No. 70, 1894—and he characterizes them as acute hallucinatory delirium, in many cases resembling delirium tremens; indeed, in many cases Lecorché asserts that it may be confounded with it. These delirious attacks usually, though not always, follow a uræmic convulsion. These patients are agitated, uncontrollable, in constant motion, anxious, a prey to fears and fancies. They have delusions, see faces and objects around them which are not present, and even talk about them with one. When delirious, they walk or march maniacally about, often repeating a single word or sentence as if their salvation depended on it.

I once attended a man of 55, who, after several months of ill-health, with increasing weakness, had vague rheumatic pains, a general "bilious state," a weak, irregular and erratic heart and pulse, with profound depression or spiritlessness, poor appetite, an enlarged liver, coated tongue, a urine loaded with urates, which was scanty and contained no albumin; of a specific gravity of 1022. Treatment directed to the liver did no good. There was a chronic diarrhœa which could not be controlled, but which was finally checked, after which he felt still worse. A few weeks later he was taken with general uræmic twitching in the afternoon, which the following night was succeeded by a violent attack of uræmic, hallucinatory delirium. This continued in a lesser or greater degree for several weeks, after which he was at times rational; but he finally, after five months, died—weak, thin, emaciated, and a shadow of his former self—from a pulmonary infarct. Albuminuria developed towards the end, and numerous casts were later detected, though his urine at times would be nearly normal.

In this case I was obliged to give chloral, at times, to control the raging restlessness of my patient. I had the unenviable pleasure of having this delirium, and the resulting mental wreck which followed, attributed by my consultant to the chloral which I had given. He had diagnosed a congestion of the liver. "Gegen die Dummheit kämpfen selbst die Goetter vergebens." The course and ending fully confirmed my diagnosis and prognosis. As Trousseau says, "One cannot know too much of the natural history of disease," for it is easily seen how such a complication of uræmia in contracted kidney may place a physician in an unpleasant position.

Therefore, there are uræmic manias and hallucinatory states, and they are dependent upon the kidney disease alone. As it clears up they generally improve, step by step. One Danish writer, Poul Hertz—*Hospitalstidende*, Nos. 8, 9, 10, 1899—asserts upon firm evidence that delirium tremens is an uræmic, hallucinatory delirium, due to an acute nephritis. He backs up this with a great number of cases and authority from the literature. I have presented his evidence in an article in the *Medical Times*, in answer to an article by Dr. Elmergreen.

We now come to the second important group of symptoms—those of toxæmic origin. These fall into two great groups. In the one they are of acute onset and great severity, and usually lead rapidly to death; in the other they are of more gradual onset, of longer duration, of less apparent severity, and of a very indefinite character. They are respectively

called acute and chronic uræmia; but, as the groups stand in strong contrast to one another, West suggests it were better to call the former "uræmia" in its ordinary acceptation, while for the latter "chronic renal toxæmia" would be the better term. There are three main theories of uræmia, which may be termed the "retention" theory, the "perverted metabolism" theory, and the defective "internal secretion" theory. The general cachexia which develops in some forms of granular kidney bears a striking and suggestive resemblance to the condition which is met with in Addison's disease, or even in myxædema; but there is no other proof, so far, of an internal secretion of the kidney.

Clinically, we know that the symptoms of uræmia are closely simulated by many conditions which at first sight appear to have nothing to do with one another; thus the typhoid state, which develops in and complicates many fevers, is like some forms of uræmia, and Murchison does not hesitate to call it uræmic.

The gastro-intestinal symptoms are often pronounced, and may be very misleading. Obstinate dyspepsia, especially if associated with pain, might suggest ulcer of the stomach; and this might be attributed, if there were much cachexia, to malignant disease, a suspicion which would be strengthened if vomiting of blood had occurred also. As a matter of fact, hæmatemesis is rare, for the hæmorrhage is not likely to be profuse; and unless it were profuse the blood would not be vomited. Vomiting is often a source of difficulty, for it is very obstinate, and does not often stand in relation to the taking of food.

West cites the case of a man aged 32, where the diagnosis of pyloric stricture had been made, and operation was proposed. The case proved to be one of granular kidney. In another instance, that of a man aged 63, malignant disease had been suggested, but the diagnosis of granular kidney was confirmed by the necropsy.

Osler—*Practice of Medicine*, p. 754—speaks of dyspepsia and loss of appetite being common. Severe and uncontrollable vomiting may be the first symptom. This is usually regarded as a manifestation of uræmia, but it may be present without any other indications; and he has known it to prove fatal with-

out any suspicion that chronic Bright's disease was present. Severe and even fatal diarrhœa may develop. The tongue may be coated and the breath heavy and urinous—a musty, urinous and foul breath, which, when once smelled, cannot be forgotten. Such patients give one a great deal of trouble and embarrassment unless the kidney disease be diagnosed.

Da Costa—*Medical Diagnosis*, p. 716—cites a case in point. An assistant nurse in the medical ward of the Philadelphia Hospital was attacked suddenly with nausea and vomiting, which persisted in spite of the remedies employed, and became so troublesome that the man had to desist from his occupation. There was no febrile disturbance; the tongue was clean; the epigastric region was not tender to the touch. Except a slight bronchitis, there were no apparent signs of disease in any organ of the body, and nothing to account for the gastric irritability. A close inquiry into the history of the patient revealed that he had had an attack of dropsy some time previously, from which he had recovered. But of late he had noticed a swelling of the feet, and on examination a slight œdematous condition was found to exist. From a combination of these signs he concluded that a chronic renal disease lay at the bottom of the gastric disturbance, and the detection of albumin and casts in the urine proved the opinion to be correct.

When to the vomiting retinitis is added, confusion with cerebral tumor is only to be expected. Morning vomiting, which is not rare, might suggest pregnancy, and West has seen these cases confused with both these conditions. The symptoms in connection with the bowels, as a rule, are not so puzzling. Diarrhœa is common with any form of kidney disease, but there are cases where diarrhœa is practically the only symptom, extremely obstinate, and almost uncontrollable. The dyspeptic symptoms are often associated with cramps. West has seen cases where cramps were the only complaint.

Cramp naturally leads to the consideration of gout, and the connection of granular kidney with gout has long been recognized.

The Cachexia of Contracted Kidney.—Patients with contracted kidney may for a long time preserve their normal appearance of health, and even when the signs of granular kidney are well marked; but, as a rule, as the kidney disease advances the

nutrition suffers greatly. Failure of health and strength in persons of middle life, without any evidence of malignant disease, should always excite the suspicion of granular kidney. The cachexia stands in direct relation with kidney wasting, and when it is extreme it is an indication that the destruction of the kidney-substance has approached dangerously near to the limits compatible with life.

The cachexia of granular kidney is characterized by anæmia and asthenia, and to some extent by loss of flesh; but emaciation is rarely carried to that degree which is met with in advanced malignant disease. It is often out of all proportion to the other symptoms, or it may exist alone. In some cases the anæmia predominates, and in others the asthenia. The blood-changes are those of simple though extreme anæmia. The asthenia is often extreme, so that the patient can hardly stand or walk without assistance. Of this extreme asthenia, West has recently seen two striking instances. One of these was under treatment for a skin affection. In this case, with rest and care, the asthenia greatly improved. In the other case the asthenia was extreme and fatal. It is so remarkable as to deserve a record.

The patient, a woman aged 41, came under observation twelve months previously for general pityriasis. She had some albumin in the urine, and was so extremely feeble that he did not expect her to live. However, after a few days' stay in the hospital she insisted on going home—as he thought, to die. However, she lived on, and in the course of time lost the skin eruption. About ten months later she appeared again, more anæmic and ill than before. She was again admitted into the hospital, where she died two or three days later. He asserts that he never saw a patient so feeble and cachectic with so little to show for it; she was like a patient dying in the last stage of malignant disease or of Addison's disease. He examined her with the greatest possible care to discover any other cause than granular kidney, but failed to find one. Even the diagnosis of granular kidney at that time was difficult, for the tension was extremely low, and the arteries but slightly thickened. There was a small amount of albumin in the urine, but not more than might have been due to her feeble condition, and the eyes showed nothing. When the post-mortem examination was made, all the organs were carefully examined, and absolutely nothing found but granular kidney. The kidneys only weighed

four ounces together. The only history that he could obtain was that she had been ailing indefinitely for about six years, but had been in fair health until the skin eruption appeared, three weeks before she was first seen. From the time when the skin eruption disappeared there had been no other symptoms except those of extreme anæmia and asthenia. The cachexia was so extreme that many thought that granular kidney was not sufficient to explain it, and that there must be some malignant disease which had escaped detection.

Nervous Symptoms.—It is in connection with the nervous system that some of the most interesting conditions arise.

Headache, which is so common a symptom, often occurs in such severe paroxysms as to resemble closely migraine. It is usually vertical, but may be frontal or occipital. When unilateral or localized, as it may be, it is often diagnosed as neuralgia or *tic douloureux*. The vomiting is no doubt often central or nervous, for it stands in no relation with food, and is frequently periodical.

Renal Asthma.—The dyspnœa, which may be paroxysmal, is very often cardiac, and usually due to bronchitis and emphysema. The respirations in uræmic states vary much; thus they may be very slow—even as low as ten in a minute—but they are deep, and there is no dyspnœa; or they may be rapid, noisy and panting, not unlike that sometimes seen in diabetics. In this form, again, there is no dyspnœa; Cheyne-Stokes breathing is usually of cardiac origin. Where there is dyspnœa it is often cardiac, and, if not, it is frequently due to emphysema and its attendant bronchitis, or the bronchitis itself may be of toxic origin. Any attack of the nature of true spasmodic asthma is very rare.

Peripheral Neuritis is a very rare condition in contracted kidney. West has recorded a well-marked case.

Epileptiform Convulsions.—Fits are, of course, the common form in which acute uræmia manifests itself, but epileptiform convulsions are not rare as one of the early symptoms of the last stage, independent of uræmia. The fits occur in groups, two or three a day, possibly, and last for a day or two; they may then disappear, and not recur for weeks or months, when a second bout of fits occurs with as little manifest cause as before, and so on. Before long grave symptoms of the usual

kind develop, and the case passes into its final stage. In connection with fits may be mentioned the curious attacks of cerebral irritation, which are not at all uncommon. They may take the form of general nervous irritability, of emotional excitement, or of almost maniacal delirium. They may last for days only, or be prolonged for some weeks, and in this condition patients have been placed in asylums as lunatics. These attacks, like the fits, are at first separated by long intervals, but gradually become more and more frequent, and finally end in a condition of chronic mental perturbation of either the excited or the melancholic type.

Skin Affections in Renal Disease.—This subject has been but little written upon, and yet clinically it is important. The cases fall into two classes, whether there is œdema or not.

Rashes Associated with Œdema.—These are for the most part erythematous in nature, transitory in duration, produce but few symptoms, and when localized have but little clinical importance. If widespread the prognosis is less favorable, and becomes the more unfavorable the more general the eruption is. Patches of erythema are often found on the inside and front of the thighs, and on various parts of the trunk, especially the lower part of the abdomen. As a rule they last but a few days, and then they do not itch nor burn, nor produce any discomfort. Sometimes the rash is of a papular lichenous character, and is then generally met with on the backs of the thighs and arms.

Eczematous eruptions are not at all uncommon if there be much œdema where the parts are in contact with each other. If the skin is leaking, as after puncture or where blebs have formed and burst, various forms of rash occur; they are often eczematous and produced by the irritation of the discharge, or erythematous, and spread in a way that closely resembles erysipelas or other infective eruptions, and are no doubt of septic origin.

As in diabetes, so in dropsy—the tissues lose their resistance to pathogenic micro-organisms, so that if infection occurs it will produce very grave results. This used to be so far recognized that puncture or drainage of œdematous limbs was regarded as a very dangerous proceeding, from the liability to phlegmonous inflammation, or even gangrene. Under the use

of strict antiseptic precautions, the danger has almost entirely disappeared.

Rashes Without Œdema.—These occur almost exclusively in granular kidney. Generally widespread or even universal, they are of great obstinacy and of grave significance. Localized eruptions similar to those described occur also in granular kidney, but these are not of much importance. The general rashes vary in character. They may be described as: 1. Erythema. 2. Pityriasis rubra. 3. Dermatitis exfoliativa. 4. General eczema. 5. A discrete papular eruption, sometimes lichenous, sometimes resembling chronic urticaria. In the initial stage it commences at the lower part of the abdomen as a localized, patchy eczema, or on the inner and front part of the thighs.

West asserts that purpuric eruptions are very rare. Other writers, as Osler and Bamberger, mentions them. I recently observed a case of contracted kidney in a man of middle age where towards the end he developed a very pronounced purpuric eruption over his body, particularly on his trunk, which persisted several days.

These rashes, of whatever kind, only occur late in the disease, and when the symptoms are well marked, so that the diagnosis of granular kidney is obvious; and this as the reason why they have been so long overlooked or not described. In cases where the diagnosis is not so clear, the patients come under treatment for skin diseases, and the essential disease is often overlooked; or, if albuminuria is discovered, it is regarded as the consequence of the affection of the skin, and its significance missed.

The association of a generalized skin eruption with albuminuria is of great importance, and justifies a more cautious prognosis than might otherwise be given. Evidence of granular kidney is often found if looked for, and then I believe the prognosis is very grave, and the end is not far off.

Acute Renal Toxæmia—Acute Uræmia.—The symptoms of acute uræmia have by no means that definite and uniform character that seems to be often assumed. The cases really vary very much from one another, almost as do cases of so-called diabetic coma. Fits and coma are the two most characteristic symptoms; and yet patients may not have fits, or at any rate no marked convulsions, and they need not be comatose. A patient may be comatose without any fits, or at most with

but very slight twitching, and the condition may then closely resemble apoplexy. Patients in such a state nearly always die.

In some cases the condition almost resembles that of narcotic poisoning. In others, again, symptoms of the most profound collapse develop. The patient seems to have been suddenly poisoned, and presents symptoms very much like those met with in acute ptomaine poisoning.

Whatever the form acute uræmia may take, the prognosis is as grave as it can be. If any one of the forms is of a less grave significance than the others, it is, perhaps, that in which there are epileptiform convulsions; for uræmic fits in granular kidney may end in recovery now and then, as they much more frequently do in acute nephritis.

Frequently signs of cerebral irritation develop, the patient becomes extremely restless, sleepless and more or less delirious, and sometimes passes into a condition of noisy, active delirium, not unlike delirium tremens, with which it has been confused. At other times the patient becomes violently maniacal, and is for the time a raging lunatic. If the patient does not die during this stage the attack may subside, and in a day or two pass off. But even then the general condition rapidly deteriorates, and other symptoms develop, which before long end in death. The most interesting fact about uræmia in granular kidney is that it may develop so suddenly, and with little or no warning, in the midst of apparent health, and carry the patient off. Granular kidney is not generally recognized as a cause of sudden death.

What with granular kidney and other acute symptoms, one may say of the advanced stages that the patient's life is hardly worth a week's purchase, so sudden may be the onset of acute symptoms, which may rapidly end in death. Yet, on the other hand, though we know that death may be sudden, yet in the absence of acute uræmia or serious hæmorrhage life may last for many years.

Finally, there is another interesting condition to which only Osler directs attention: the tendency of cases of granular kidney to have occasional or terminal attacks—"congestive attacks" of the English writers—which in the beginning, at first sight, before the examination of the urine clears up the case, resemble an oncoming typhoid fever. These patients will tell you that they have been feeling bad for a week or two before taking to bed, that their head aches, they feel tired, drowsy, sleepy, chilly, with aching in the back and limbs. They may be constipated or diarrhœic, their tongue is coated, probably with a reddish margin and tip, with a whitish-yellow centre. They have no appetite, have been vomiting, possibly repeatedly, with a blind-

ing headache, which is simply agonizing. When they raise up their head they become giddy and have to lie down again. Their pulse may be weak, and fast or bounding and full, or full and slow. Take their temperature, and it is from one to five degrees above normal. A chill may have initiated the disease or anticipated the aggravation and the final giving up and going to bed. Examine the abdomen, and it is found bloated, painful here and there, with some gurgling in the right iliac fossa, where pain is also experienced. Now, these patients are not usually of the age where typhoid is met with, but rather those of middle and past middle age. They have been hard workers, heavy eaters, great brain-workers—rather the two latter combined. Yet I have met with this state in young persons. Now, what is more natural than to conclude that a typhoid is threatening here or is already here?—a serious diagnostic error, and which will bring a man into great embarrassment. If you crowd such a patient with beef preparations and the rich nitrogenous foods of the typhoid dietary, you will disorder the stomach, feed the fever, reduce the patient to beyond help, and bring matters from bad to worse until he either passes into other hands or above, to a better land. Possibly a convulsion may vary things. I have seen such cases, where they were thus crowded with rich nitrogenous soups and broths, carry a high temperature, with increasing emaciation, rapid and weak pulse, drowsiness, and a heavily- and dirtily-coated tongue, with a blackish-brown streak down the centre, who, between the nitrogenous broths on the inside and the cold packs on the outside to reduce the fever, would rapidly emaciate, and, in fact, burn up, with the high temperature carried. Some of these cases closely resemble a meningitis tuberculosa. They may go on for weeks in this state. It is easily diagnosed by examining the urine, when a darkish-colored urine, usually thin in specific gravity, loaded with albumin, with numerous hyaline, and possibly some darker granular, casts, can be found. An acute or subacute nephritis grafted on an old granular kidney explains the whole clinical picture. As complete a work as that of *Curschmann on Typhoid Fever* does not mention these states as to be differentiated.

Finally, be on your guard at all ages for granular kidney. When in doubt, examine the urine. Contracted kidney is not the exclusive privilege of advanced age, and neither does it come under our eyes labeled “contracted kidney.”

SWELLING OF THE LIPS.—For swelling of the upper lip, with or without hardness, *Bell.*, *Merc. Sulph.* and *Calc.* For cracking and bleeding of the lips, *Arsen.*, *Bry.*, *Carbo veg.* and *Ignatia.*

THE CARE OF CANCER CASES.

BY B. FRANK BETTS, M.D., PHILADELPHIA.

(Read before the Germantown Homœopathic Medical Society.)

ALTHOUGH malignant neoplasms differ in their morbid anatomy, and to a certain extent in their clinical manifestations, it is convenient and permissible, for the purpose of this paper, to include all varieties in the term Cancer; and whilst the suggestions respecting the care of these cases will apply to the disease in almost any part of the body, they are intended in an especial manner for cases in which the uterus is primarily involved.

With the results obtained by the surgical treatment of this affection within the past decade you are, perhaps, all familiar, and it is unnecessary for me to add anything to the statistics already published to convince you of the curability of the disease when operative treatment is resorted to in the earliest stages, for this question has been fully and definitely settled in the published reports of the clinical results obtained by gynæcological surgeons who have been interested in this work for the past fifteen years. Yet the proportion of cases which are so far advanced as to be positively inoperable when they first come to us is still too large, and we are obliged to risk too much in operating cases not so far advanced beyond the stage of positive curability as to give rise to the expectation that we may reach and remove all malignantly involved tissues by either the complete abdominal or vaginal method.

To the assertion that valuable lives are almost uniformly saved by early operative treatment, we are therefore obliged to add that a much greater number perish, because the diagnosis of their condition is made too late for operative treatment to be efficient.

In the year 1893 London is said to have lost 3412 of her population from this disease alone,—a percentage of 3.73 of the total death-rate for the year. Prior to 1885, hysterectomy for the removal of cancerous uteri had such high mortality—

at least 15 per cent.—that it was looked upon with disfavor; but total vaginal extirpation was after that so successfully practiced by Martin, Leopold and Olshausen, that this operation became much more popular, and the mortality has been reduced to at least 4 per cent., if not lower. The mortality of London in 1893 from cancer cannot include, therefore, a very great number of operative cases.

These facts are so well understood that I need not offer an apology for bringing this subject to your attention, in order that we may discuss the best means of reaching an early diagnosis in this very serious affection.

To arrive at a satisfactory diagnosis in the earliest stages of the disease we are required to direct close attention to all the clinical evidences obtained from the patient, including a carefully conducted physical exploration, and supplement this by a competent microscopical examination of specimens of tissue obtained from the portion of the organ supposed to be most affected. By means of the long-handled tenaculum and a long knife a piece of tissue can be readily taken from the cervix, or pieces of the mucous membrane lining the uterine cavity can be secured, by means of a small curette, for microscopical investigation. Evidences obtained in this way are mostly conclusive. It is from neglect upon the part of patients who fail to consult their physicians, or physicians who fail to appreciate the responsible position they assume in such cases, that these patients are permitted to pass swiftly to their doom without opportunity for relief.

The willingness to wait for profuse hæmorrhage, offensive discharges and pain, is responsible for the fatality in these cases.

Howard A. Kelly, in a summary of the means proposed to prevent excessive mortality from cancer, says: "The community at large should be so trained by the profession that any woman who suffers from an unusual or atypical uterine hæmorrhage, or from any unusual discharge, should at once seek competent advice as to its cause;" and I would emphasize the fact that in doubtful cases no investigation can be considered complete which does not include the microscopical examination of the tissues supposed to be affected. If we will subscribe to a slight addition to the surgeon's code, which recognizes in abnormal hæmorrhage a need for prompt assistance, and keep in

mind the rule that metrorrhœa or abnormal uterine discharges demand prompt investigation, its application to women over 30 years of age, and particularly to those who have passed the climacteric, will save many lives, by enabling us to meet the requirements for these cases promptly.

Our patients should understand that an abnormal flow of blood after sexual intercourse, straining, or any unusual effort, may be a serious symptom.

It may, of course, be due to a cervical polypus, an erosion, or some urethral or vulvar condition of minor importance, but, on the other hand, it is more probably due to a cancerous degeneration of the cervix that may reach a fatal termination within a few months if neglected. Abnormal uterine discharges demand prompt investigation.

The return of the flow after an absence of many months, at a period when the menopause is expected, is not, as many suppose, an evidence of rejuvenation, but is often a symptom of grave pathological importance. It is to be remembered that a normal menopause secures to the patient a cessation of the flow, not an increase, as many suppose. It is at this period of life especially that *metrorrhœa demands prompt investigation*.

It is admitted that there are cases occasionally met with in which it seems impossible to make a satisfactory diagnosis by the employment of all our modern methods at the *first* examination, for it is not always possible to draw a clear and fast line between malignant and benign conditions. Under such circumstances we are justified in waiting a few weeks for new developments, when another investigation should be made. Spiegelberg's sign—immobility of the mucous membrane upon the subjacent structures—is valuable as pointing to malignancy, but it is not pathognomonic; nodular hypertrophy is suspicious, but not conclusive; the tendency to bleed from contact is a very important symptom, yet in all doubtful cases the evidence derived from the microscope is more conclusive. To such patients as appear to have reached the border-land of malignancy we, of course, prescribe remedies during the time they are under observation, according to symptomatic indications. We need never lose sight of the patient whilst we are watching for the tumor; but a more serious mistake is made if we lose sight of the tumor whilst watching the patient.

When the cervix has been lacerated at childbirth, it should be repaired before there is any malignant development; and when it bleeds easily, and has spongy looking patches upon it, the value of local applications of hydrastis in glycerin has been verified in numerous instances by many members of our profession. Tampons of antiseptic wool covered with this preparation answer a good purpose. The remedy is administered internally at the same time in the third dilution, if the patient suffers from hepatic torpor, constipation, impaired digestion, borborygmus, eructations, mental apathy and forgetfulness. The internal administration of lycopodium is called for in many cases, as well as calcarea, sulphur, silica and the kali's.

Although this disease has not been conclusively traced to germ influences, we do well to take into account the environment and the hereditary predisposition of our patients when they are subjected to treatment. In certain apartments several persons have been afflicted with cancer in succession, and a damp soil is said to favor the development of the disease in many instances. It has seemed to be most prevalent along certain water courses. My observations lead me to think that damp neglected cellars are important ætiological factors.

In many of those who have died of cancer the pulmonary artery has been found to be smaller than natural, and therefore it has been suggested that chest exercises might retard the growth of the neoplasm by increasing the pulmonary area and driving out residual air. These are mere hypotheses, however. There is, of course, a precancerous stage in every case, and the correct application of our remedies, with careful attention to hygienic requirements, may be all that is needed to prevent a malignant development, or at least to determine between a tardy and a rapidly fatal termination. Efforts for prophylaxis should therefore be most diligently made in all suspicious cases, and in those previously operated in which a recurrence is feared.

A genial climate, plenty of sleep, which favors the elimination of waste products, freedom from nerve strain, plenty of exercise, a simple diet, good digestion, fresh air and sunlight, are conditions especially required to secure health for our climacteric patients, and should be provided, if possible, for all patients in whom there is a suspicion of cancer.

When the disease is met with in an advanced stage we en-

counter difficulties which are due to our inability to determine with positiveness the extent of the involvement of neighboring structures, which has an important bearing upon the surgical treatment of the case, for without the diseased structures can be completely removed by the operation, grave doubt must always be entertained respecting the advisability of any surgical interference.

In some cases it is impossible to determine the extent of the involvement of neighboring organs until these structures can be examined during the operation. When the rectum, bladder, or the ureters are found to be implicated in the malignant process, and a speedy death or the establishment of faecal or urinary fistulae through the abdominal incision awaits the termination of the operation, the best course for the patient is the abandonment of further operative efforts. After the removal of the ovaries, and the ligation of the ovarian arteries so as to abolish the menstrual flow, these cases, like cases of tubercular peritonitis, have experienced such an improvement as to lead to the supposition that curative results have been attained. Unfortunately, under the circumstances, a microscopical examination of the tissues is very likely to be neglected, so that the diagnosis of cancer cannot be substantiated. In the writer's experience some very suspicious cases have gone on to complete recovery after an abandoned operation which would have been fatal if it had been completed at all hazards.

In those cases in which the cervix, the vaginal walls and the base of the broad ligaments are extensively involved no operative treatment avails, unless a curettement of the diseased area is called for in order that the pent up secretions in the uterine cavity and crevices of the diseased mass may be liberated. The removal of these offensive discharges will add to the comfort of the patient and her friends, and will limit septic infection.

The only object attained, however, by this mode of treatment, in far advanced cases, is the limitation of hæmorrhage and offensive discharges.

In many of these cases of uterine cancer the kidneys have become seriously diseased; such patients do not bear prolonged operations well, so that it may be said that a case too far advanced for total extirpation of the uterus is often too far advanced for operative treatment of any kind, unless it can be

done quickly under chloroform narcosis. Unfortunately, the thermo-cautery is often required to control hæmorrhage after curettement, and it cannot be employed safely or satisfactorily without an anæsthetic. In such cases the objects of treatment are only palliative, and they must be conservative to be advantageous.

A cherry-red solution of the permanganate of potash is most frequently employed as a vaginal douche to allay the offensiveness of the discharges, but it is often used in quantity too small to be efficient. A copious douche is required, and in some cases the 1 to 4000 bichloride solution answers a better purpose. A saturated solution of alum should always be available, and ready for the patient's use as a vaginal douche to control excessive hæmorrhage.

Moderate pain with slight hæmorrhage may be controlled by an 8 per cent. solution of cocaine carefully applied to the diseased structures, if there is not too much necrosed tissue to prevent absorption.

When pain becomes very severe it may be found necessary to use morphia hypodermically, or opium in the form of rectal suppositories. If cocaine is used in conjunction with opium it proves beneficial as a stimulant to the respiratory centres, and the heart's action improves.

The establishment of an opium habit in the early stage of cancer has nothing to recommend it for the purpose of inhibiting the development of the disease, as is claimed by some authorities. Our line of treatment will give better results in the care of such cases, as well as for those which are so far advanced as to be inoperable.

Many attempts have been made to limit the further extension of the malignant process by *local applications* to the parts affected, or by injections into the same. As a local application, the persulphate of iron has seemed to have some controlling effect through its influence in clogging the circulation of the parts, and I have used it as an injection into contiguous areas; but it is unpleasant to use locally, and difficult to inject except in a very weak solution.

Coley's mixed toxin treatment by the local injection method should be reserved for inoperable cases. There may be some ground for the hope that it will limit the progress of the dis-

ease, but it cannot be recommended as a curative means in operable cases as a substitute for pan-hysterectomy.

Of the injection methods of treatment to control the disease in operable cases, and for those that have been operated and have suspicious nodules develop subsequently, the Hasse method is the only one that deserves a trial.

Hasse injects 60 minims to 80 minims of alcohol, diluted to 30 per cent. or 50 per cent., into the area around the growth, at intervals of three or more days, according to the amount of local reaction set up. Injections into the substance of the growth are not attended with beneficial results. Hasse reports the most satisfactory effects from this treatment, extending over a period of nearly a quarter of a century. It is applicable to those patients who have been operated and require watching for a considerable time to guard against a recurrence of the disease.

I have used strong, sterilized, boiled alcohol, injected into the tissues contiguous to the suspected area through a long hypodermic syringe needle, previously sterilized, after vaginal hysterectomy, when suspicious nodules of tissue develop. A tenaculum should be held by an assistant, firmly implanted in the tissues, whilst the needle is introduced beneath the mucous membrane, and at a healthy point. At first only 5 or 10 minims are injected into each of three or four punctures at one sitting. After a week the process is repeated as frequently as the case seems to demand.

In these cases the surgeon's responsibility does not cease when the patient is able to resume her duties subsequent to an operation, for evidences of a recurrence are to be promptly treated by internal medication and the alcohol injections. Regular examinations should be made at stated intervals, to be determined by the physician in charge of the case, for some months afterward.

The conclusions reached from the consideration of this subject are to the effect that, First, in the care of cancer cases we assume grave responsibilities, for in the earliest stage we should reach a diagnosis promptly, and the necessity for operative treatment should be speedily recognized. Secondly, in the inoperable stage we are required to aid and comfort those to whom we are called to minister, for cases of cancer in this

stage are often left without adequate treatment. Thirdly, with the modern antiseptic methods at hand the skilled surgeon goes to no case more cheerfully than to one of operable cancer, which may be permanently cured by his efforts.

ABDOMINAL REMEDIES—INCLUDING SYMPTOMATIC INDICATIONS
FROM FARRINGTON, HERING, AND OTHER LEADING
MEN OF OUR SCHOOL.

BY EDWARD FORNIAS, M.D., PHILADELPHIA.

Nux Vomica.—The chief vascular disorder indicative of this drug is of venous origin, and consists of a marked sluggish condition of the portal circulation, with consequent abdominal plethora and hæmorrhoidal fulness, which, when associated with constipation, is a constant source of passive congestion of the liver and of the lower spinal vessels, which often accompanies affections of the female sexual organs.

One of the forms of dyspepsia in which I have used *nux vomica* with great satisfaction to myself and benefit to my patients is that especially connected with portal and hepatic congestion. An attack of hæmatemesis, or of hæmorrhoidal bleeding, by removing the congestion may afford comfort to the patient, but the distressing symptoms are readily reproduced. The abdominal plethora, indicative of this remedy, is easily understood if we bear in mind that sedentary habits, accidental indiscretion in diet, or intemperance, or a long-continued excess in food or in stimulants, are important factors in the production of sluggish liver, an organ always at the mercy of its four sets of tubes, the portal veins and hepatic artery engaged in bringing material, and the bile ducts and hepatic veins in carrying away. "It should be remembered that the pains indicative of *nux vomica* are not those caused by inflammation but by spasm, and that the attacks of fainting with which many abdominal disorders are associated are chiefly due to the fact that, as a larger supply of blood is sent to the stomach, less is conveyed to the brain, causing a temporary failure of power." The aggravation after eating is a characteristic symptom of *nux vomica*, but the student should bear in mind that hepatic con-

gestion always accompanies the digestive act, and is apt to exceed its normal limits whenever food is taken in excess, or is of an irritating nature, especially when connected with alcoholic abuse. Hence the importance of regulating the diet of subjects thus affected.

"*Nux vomica* agrees with *sepia* in causing portal stasis, uterine congestion, hæmorrhoidal distention; urging to stool; back-ache, worse from motion; awakes at 3 A.M." "The analogues of *nux vomica* in hæmorrhoidal distention are several: First, *æsculus hippocastanum*. This is a wonderful remedy in abdominal plethora. You will find it indicated when there is deep throbbing in the abdomen, particularly in the hypogastric region, with blind or bleeding piles and a feeling of dryness in the rectum, as though little sticks or splinters were pricking the parts. That is the key-note for *æsculus*."

"The next remedy that I will mention in this connection is *aloes*. This drug has abdominal plethora and flatulence, like *nux* and *sulphur*, and hæmorrhoidal distention like *nux*, *sulphur* and *æsculus*. But it differs from them in that it acts almost entirely on the rectum, producing stools which are accompanied by an immense expulsion of flatus."—(Farrington.)

"*Collinsonia* is indicated in hæmorrhoidal distention, when there is a sensation as of sticks in the rectum. It is also useful in prolapsus uteri with hæmorrhoids." "It is in constipation and hæmorrhoids from congestive inertia of the lower bowel that *collinsonia* proves such a precious remedy, especially in the latter months of pregnancy."—(Hughes.)

"*Sulphur* seems to act prominently on the venous circulation, producing fulness of the abdomen from venous plethora. This plethora is the result of irregularities in the distribution of the blood, by which certain parts of the body become congested. These congestions, generally speaking, are such as occur particularly from abdominal trouble, especially fulness of the portal system, and arising from sudden cessation of an accustomed discharge, as the hæmorrhoidal flow."—(Farrington.) *Sulphur* is useful in many abdominal disorders (intestinal or hepatic) attended by passive congestion of the portal system, as indicated by the sensation of fulness in the abdomen, even when taking the smallest quantities of food, by the enlarged, sensitive liver, and by the hæmorrhoids and constipation, which are the direct result of this abdominal plethora.

“So as *sulphur* acts through the venous capillary vasomotors, paralyzing them and permitting a passive venous congestion, *calcarea ostrearum* exerts its primary action on the fibres supplying the lymphatics, causing paresis and atony of the glands, and so permitting a glandular obstruction from want of tone to expel the contents, thus favoring the impoverishment of the blood. From its paralyzing action on the abdominal vasomotors *sulphur* produces abdominal plethora from venous stasis, while *calcarea* causes mesenteric glandular enlargement by obstruction, owing to its action on the nerves of these glands; so in both we have a large abdomen.”—(McIntyer.)

In abdominal disorders of ill-nourished, obese, delicate children, with strumous manifestations, I have prescribed *calcarea ostrearum* with brilliant success. My guides to distinguish between *calcarea* and *silicea*, either in tabes mesenterica or marasmus, have always been the sweat, the abdominal temperature, the appetite, and the stools. I give *calcarea* if the head-sweat and abdomen are cold and the child is constantly nursing or craves eggs, especially if there is hyperacidity, obstructed flatulence, and tendency to serous, offensive stools, with prolapsus recti. I employ *silicea* when the sweat is sour or offensive, the abdomen hot, the child has aversion to the mother's milk, or any warm, cooked food, principally with tendency to constipation. But when there is alternation of constipation and diarrhœa, and the child emits an offensive odor, and dislikes bathing, I have often turned to *sulphur* with the best results, especially if, due to the character of the stools, the anus becomes sore and swollen, or there is a great craving for nourishment, as well as a marked contrast between the large abdomen and the emaciated limbs.

In these visceral disturbances *sepia* also resembles *sulphur*. “Both are suited to torpid cases with defective reaction. There are abdominal plethora, congested liver, hæmorrhoids, constipation, hunger about 11 A.M.; bitter or sour taste; eructations, sour or tasting like bad eggs; fulness from little food, etc. In *sulphur* the hunger is experienced at 11 A.M.; while in *sepia* it is more of a gone, faint feeling. The constipation in both is attended with ineffectual urging, like *nux vomica*.”—(Farrington.)

Lycopodium is a very worthy rival of *sepia*. In both there are abdominal plethora, congested liver, constipation, and flatulent

distention. "A sensation of emptiness in the epigastrium is more characteristic of *sepia*; repletion after eating, of *lycopodium*. Indeed, with the last-named, the repletion overshadows the other symptoms, often existing without any alteration in the appearance of the tongue. Sour taste and sour or burning eructations are, however, very common. The abdomen is in a state of ferment. After eating, the circulation is disturbed, with irresistible drowsiness. The urine contains a sediment of free red sand. The bowels are constipated with urging and constriction of the anus. The urine, however, is not so offensive as under *sepia*."—(Farrington.)

"*Lycopodium* is one of the leading trio of flatulent remedies, *carbo veg.* and *china* being the other two. With *lycopodium* there seems to be an almost constant fermentation of gas going on in the abdomen, which produces a loud croaking and rumbling. Remember, while *china* bloats the whole abdomen, *carbo veg.* prefers the upper and *lycopodium* the lower parts. With *lycopodium* this flatulent condition is very apt to occur in connection with chronic liver trouble. Again, this rumbling of flatulence is often found, particularly in the region of the splenic flexure of the colon or left hypochondria. A feeling of satiety is found under this remedy, which alternates with a feeling of hunger of a peculiar kind. The patient sits down to the table very hungry, but the first few mouthfuls fill him right up, and he feels distressingly full; in a Pickwickian sense, 'too full for utterance.' This alternation of hunger and satiety is not so markedly found under any other remedy."—(Nash.)

If we study these remedies still further, we shall find that both produce not only acidity and abundant flatus, with abdominal distention, but constipation, hæmorrhoidal tumors, hepatic tension and soreness, and a feeling of fulness after eating. The flatulence of *lycopodium* accumulates in the abdomen and becomes incarcerated, hence more croaking and rumbling, with pressure upwards, or downwards on to rectum and bladder. That of *carbo veg.* escapes abundantly, upwards and downwards, is very offensive, and relieves the distention. With *lycopodium* the feeling of distressing repletion occurs immediately after eating the smallest amount of food, and is quickly followed by hunger again. With *carbo veg.* the fulness is principally after late meals, and only a mouthful of food aggravates the accom-

panying symptoms; in fact, there is dread to eat because of burning pains. Both have sleepiness after eating, but it is more marked in *lycopodium*, where it is apt to amount to drowsiness. The eructations of *carbo veg.* are principally of a rancid taste, of *lycopodium*, acid. Milk disagrees with both.

Cinchona also produces great accumulation of flatus, with consequent distention. Excessive tea drinking seems to be a predisposing cause. As with *lycopodium* the incarcerated flatulence produces colicky pains, and there is a feeling as if the abdomen were packed full, not relieved by belching. In *cinchona* there is, as a rule, aversion to all food, and a feeling as of having eaten too much. "Like *carbo veg.* it has dark, offensive, fluid discharges, both have the distention of the abdomen, both have great weakness and hippocratic face. With *cinchona*, however, the movements from the bowels are provoked by every attempt to eat or drink. Belching gives but temporary relief. Again, the flatus is not so offensive as with *carbo veg.*, nor are the burning pains so marked as under *carbo veg.* or *arsenicum*."—(Farrington.)

In tympanitic abdomen, or in spasmodic constrictive pains from incarcerated flatulence, I have frequently found this remedy beneficial.

As *pulsatilla* acts so markedly upon the right-heart and veins, it often relieves the symptoms depending on the sluggish flow of blood through the abdomen. The retardation of the venous flow, with its consequent plethora, caused by *pulsatilla*, seems to be intermittent and attended by the characteristic throbbing or pulsations of this drug. *Pulsatilla*, like *æsculus*, has deep throbbing in the abdomen, but in the former it is perceptible at the pit of the stomach. Pulsation in the pit of the stomach is also found under *cinchona*. Further evidences of this venous stasis we find in the hæmorrhoids, varicose veins and passive hæmorrhages, as well as in the amelioration in the open air. Then, again, its influence upon the vasomotor nerves explains the constant sensation of chilliness attending the visceral disturbances in which *pulsatilla* has proved curative; and capillary venous congestion may be the cause of the feeling of subcutaneous ulceration, a kind of inner soreness, present in many thoracic and abdominal affections, and quite characteristic of this drug. Moreover, *pulsatilla*, like *nux vom.*, *lycopod.*, *carbo veg.* and *sulphur*,

has aggravation after eating. It produces flatus in abundance, with consequent distention, shifting colic, oppression and other distressing phenomena. It is a butyric acid fermentation or chemical change supervening after partaking of fatty substances or food prepared with fat, such as milk, cream, pork, cheese, ice-cream and pastry, and which give the peculiar sourness to the ejected matters in dyspepsia. I have seen this drug indicated more than any other in the so-called amylaceous dyspepsia of children, even more so than *carbo veg.* and *sulphur*. Attending these visceral derangements we have sometimes weight, as from stone, early in the morning, on waking, or one or two hours after eating, > by eating again (*anac.*, *lycop.*), as well as gnawing distress when the stomach is empty; pressure and pinching after eating, with rancid eructations, or eructations tasting and smelling of the food taken, and perceptible pulsations in the pit of the stomach.

Cocculus is a remedy occasionally called for in abdominal affections. It produces abundant flatulence, with dyspnœa, rumbling, distention, and pains of a twisting, crampy nature in the hypogastrium. Like *sepia* has an empty feeling in the abdomen, which is characteristic. Moreover, we find under this drug such common attendants of these troubles as nausea, compressive weight in the stomach, constipation, great anguish and nervous excitement, with disposition to be frightened. Belching relieves, but the escape of flatus downwards does not. As with *colocynthis* there is a sensation as if stones were in the abdomen; with *cocculus*, however, the feeling is as if the abdomen were full of sharp stones, rubbing together on every movement, while with *colocynthis* as if the intestines were being squeezed between stones.

By the above it is plainly seen that *colocynthis* is also a valuable abdominal remedy. It has distention, tympanitis, incarcerated flatulence, and severe colic. The constrictive, crampy pains are more violent than under *cocculus*, and, like *aconitum*, the patient seeks relief by pressure against the abdomen, and is full of anguish and agitation. As with *cocculus* and *sepia*, there is a feeling of vacuity in the abdomen, but not so characteristic as in these remedies. The least amount of nourishment renews the colic, or brings on diarrhœa, and drinking coffee, smoking, or the passage of flatus, relieve the pain. In phys-

conia adiposa, especially with women who have had many children, it stands uppermost in the list; and in enteritis, when the slimy, bloody stools look like scrapings of the bowels, it shares honors with *colchicum* and *cantharis*.

Arsenicum is another remedy frequently called for in deep-seated abdominal troubles. I have found it particularly useful in those cases in which constipation has been replaced by diarrhœa, with severe burning pains, great anguish, no rest anywhere or in any position, and despair of life. The stools are usually scanty, frequent; mucous or serous, like dirty water; always acrid or with burning pains, and worse after midnight or in the morning after rising. In all abdominal diseases where high fever and burning pains are present, or where the gastric irritability is such as to reject all class of liquids and water, or where, notwithstanding the intolerance of water, there is great thirst for small quantities at the time, we will consult *arsenic* with advantage; and it is invariably indicated when, in addition to these symptoms, there is a persisting, dry, nocturnal pyrexia, with marked sinking of strength and progressive emaciation. I would also especially call attention to the use of this drug in the melæna of typhus and other low fevers, in morbus niger, and in ascites.

Apis mellifica is one of the remedies with which I have been able to relieve ilio-cæcal, inflammatory localizations, regarded as out of the reach of therapeutics, and, according to specialists, demanding surgical interference. The rigid, tense abdomen, the stinging pains in the ileo-cæcal region upon pressure, the œdematous condition of the surrounding parts below, the constipation, the feeling of tight pulling at the cæcum when straining at stool, the nervous restlessness, the high temperature, and the dark, scanty urine, led me once unhesitatingly and successfully to its employment in appendicitis. Again, its usefulness in many cases of dysentery, ascites and peritonitis with exudation is well known.

Equally important, if not more so, is *mercurius* in the treatment of inflammation of the appendix vermiformis and its surrounding tissues. It is our leading remedy after pus has formed either in the cæcum, peritoneum or liver, and septic poisoning becomes imminent, as indicated by muscular twitchings, bitter vomiting, putrid diarrhœa and nocturnal pyrexia,

with anxiety and restlessness. If with these symptoms we should notice by palpation a hard, painful, hot swelling in the ilio-cæcal region, and the pain is increased by flexing and extending the thigh, we are surely dealing with abscess in or near the appendix. Other abdominal troubles in which *mercurius* is often indicated are attended by chills, heat and redness of the cheeks, and profuse sweats without relief, as well as by rigidity, bloating, and great sensitiveness to all contact or the least pressure. It is of great value in enteritis and dysentery, and in duodenal catarrh and gall-stone it becomes frequently a priceless remedy.

Plumbum has in its pathogenetic symptoms which lead us to expect good results from its application in deep-seated abdominal inflammation, particularly in serious cases, when gangrene sets in. Under this drug we find: Large, hard swelling in the ilio-cæcal region, painful to touch and motion. The abdominal walls are hard as stone, the recti muscles knotty, the navel retracted, and there is anxiety and restless tossing, with cold sweat and deathly faintness. Such are the usual concomitants of the violent constrictive pains indicative of this remedy in the various forms of severe colic. In incarcerated hernia or intussusception, with colic and fecal vomiting, this remedy stands uppermost in the list.

Besides the drugs mentioned above, I wish to call especial attention to *lachesis*, which has already gained a deserved reputation in hepatic abscess, and is well indicated by its pathogenesis in all inflammatory visceral troubles attended by a marked hyperæsthesia of the surface of the body to the least touch or contact. Like *mercurius*, it is indicated after pus is formed, and shares honors with *plumbum* when gangrene is imminent, in which latter condition also follows well *arsenicum*. *Lachesis* cannot be overlooked in acute peritonitis, either idiopathic, perforative or secondary to inflammatory disease of adjacent viscera, as septic endometritis and appendicitis; and this is particularly the case when the abdomen is hot, painfully stiff, and so sensitive that the least contact with the bed-covering distresses the patient, or when the pain and tenderness are so intense that abdominal respiration and body movements are inhibited, and the patient lies on his back, with flexed thighs and pinched features, and there is persistent vomiting and con-

stipation. It should be studied in metritis, ovaritis, pelvic cellulitis, appendicitis, typhlitis, or any other abdominal disease in which this extreme sensitiveness to the least contact is present. In a case of infectious salpingitis under my care, in which this hyperæsthetic condition of the abdominal walls was markedly manifest, the administration of a few doses of *lachesis* was followed by a free discharge of pus from the uterus, thus averting a probably fatal peritonitis.

Rhus tox., on account of its affinity for the right side of the abdomen, has often been employed successfully in visceral disease with this particular localization. In typhoid fever it has a brilliant record, and it is no less valuable in enteritis, appendicitis and peritonitis with typhoid symptoms. Like many of the preceding drugs, it produces gaseous distention, tympanites and sensitiveness, especially over the right iliac region, with pains and sensations of various kinds, such as: Cutting as of a knife in right abdomen; burning in the right side of the abdomen; constant pressing, burning pains in whole right abdomen, and sensation as if something were torn loose, or as if a lump lay like a pressing weight. Another disorder of sensation characteristic of this drug is soreness, as if beaten, in the hypochondria, but particularly in the abdominal walls.

And, finally, *aconite* is to be thought of in the initial stage of all visceral inflammation accompanied by high fever, anxiety, fear of death, jactitation, oppression, sensibility to touch, and unbearable pains, with lamentations and tossing about.

To end this paper, I may be allowed to state that therapeutics holds only a subordinate place in the treatment of many acute inflammatory diseases of the abdominal viscera and their envelopes, especially when threatening abscesses form and there is danger of septic infection. I do believe that whenever localized pain of a severe character is attended or followed by chills, distinct rigors and high temperature, we will often find our remedies insufficient to effect a cure without the aid of surgery; but, at the same time, who can deny the existence of cases in which the knife is ill-advised and unnecessary? I can draw a parallel by referring to two cases of infectious salpingitis under my care—one mentioned above, and treated successfully by *lachesis*; the other where sudden and severe constitutional symptoms led me to expect a fatal issue, and where an oppor-

tune laparotomy by Dr. Vischer saved the life of my patient. Two recent cases, from my note-book, demonstrative, again, of the limitation and absolute power of therapeutics, are the following: A very old lady suffered from rheumatoid arthritis, with severe knee localization, and, under the administration of the indicated remedies, the best cure that could be expected at her advanced age was accomplished. The other, also an elderly lady, was treated last summer in one of our seashore resorts for rheumatic gout, and on her return to the city sent for me. After a careful examination of the case I found that a mistake had been made, and that I had to deal with a case of traumatic synovitis. Dr. Van Lennep was called in consultation. He verified my diagnosis, and after prolonged rest, pressure by bandaging, and the internal administration of *bryonia* and *sulphur*, the patient is to-day on the way to recovery.

These cases readily explain the imperative necessity of knowing well the meaning and intrinsic value of symptoms in order to determine whether therapeutics alone is sufficient to effect a cure, or whether surgical aid is required.

SURGICAL TREATMENT OF UTERINE FIBROIDS.

BY J. H. M'CLELLAND, M.D., PITTSBURGH, PA.

(Read before the Southern Homœopathic Medical Association, Oct. 18, 1899.)

THE title of my paper relieves me from all consideration of this interesting subject (uterine fibroids) save the most expedient and successful methods of surgical treatment. The hypodermatic treatment by ergot and the local treatment by galvanism can hardly be included in this.

The most accepted methods to be here mentioned will be illustrated by cases of recent date operated upon by me, drawn from the records of the Homœopathic Hospital, Pittsburgh, and kindly furnished by the Residents, Drs. Calhoun and Twitchell.

We recognize, as varieties, the submucous (polypoid), the interstitial or intramural, and the subperitoneal; the latter are not infrequently of mixed type, such as the cystic myoma, etc.

The above varieties call for different surgical measures. Indeed, the propriety of surgical treatment at all depends upon somewhat definite conditions.

The uterus may have one or more subperitoneal nodules, or even tumors of considerable size, which apparently occasion but little distress; or, if there is metrorrhagia, it may be controlled in certain cases by other means, which would obviate the necessity for operation, at any rate, for the time being. We should be satisfied that the tumor is increasing rapidly, or that existing conditions call for operation.

The first question to be decided after an operation is determined upon is, By which route?—*i.e.*, per vaginam, or by cœliotomy. The elements entering into this question relate to the size of the growth, its (their) location, and especially the complicating conditions. All other things being equal, I prefer the abdominal route.

Submucous fibroids are to be reached per vaginam, especially when pedunculated. Small fibroids of the subperitoneal type may also be reached per vaginam. Then, the route being chosen, the question of a myomectomy or hysterectomy (supracervical or complete panhysterectomy) is to be determined. Except for the pedunculated submucous variety, I prefer to do only the complete hysterectomy by the vaginal route. There are the rare exceptions of small fibroids in the cervix itself, which can easily be reached through the vagina. By cœliotomy, then, the majority of cases of uterine fibroids can be best and most successfully treated surgically. Upon opening up the abdomen one can quickly determine the most appropriate procedure.

1. If the tumor or tumors are small or pedunculated, enucleation or incision is to be preferred, especially in young women. This is easily done by transfixing the pedicle with a double ligature—I prefer silk—and then, after removing the growth, covering-in the stump with fine sutures of catgut. If the nodule is intramural, care must be observed, after it has been enucleated, to close-in the cavity with a sufficient number of catgut sutures.

2. It often happens that the ovaries are in a damaged or degenerated state, in which case the diseased ovaries may have to be removed in whole or in part. If the former, then it will

not be so important to save the uterus, and it becomes a question whether a hysterectomy had not better be done, instead of the more conservative operation.

3. In large or distinctly intramural myomata we at once decide upon a hysterectomy, if this can be done with a fair promise of success. It becomes a matter of choice or expediency whether this shall be an amputation through the cervix or a complete ablation. I prefer to leave the cervix when this is feasible, and, as a rule, drop the stump into the abdomen,—having made a wedge-shaped surface which can be approximated securely with catgut sutures and covered-in with peritonæum. There are cases, however, where the tumors completely obliterate the cervix, so far as a pedicle is concerned, and we have no choice but complete removal. In some cases this is most difficult. The tumor may be entirely subperitoneal, so far as the pelvic cavity is concerned, and fit in like the descending head of a child—adherent and immovable. I have succeeded in several of this class, but in some (IV.) I have been content to remove the ovaries, and with excellent effect in arresting the growth of the tumor. I believe this old procedure should not be thrown aside entirely, as in two cases which occurred, one and five years ago respectively, the large abdominal masses have gradually subsided to less than half their size, and the patients, in the meantime, have recovered from most distressing pressure-symptoms.

The following cases illustrate in a practical way the points above made, and are only out of the ordinary in some particulars:

CASE I.—Mrs. C. K., æt. 30. Married several years and barren. February 3, 1898. Found a narrow, bent cervix, and a tumor, size of an egg, in right broad ligament, close to uterus. After dilating and curetting the uterus an incision was made in the posterior vaginal fornix, and the tumor drawn down and ligated and removed. The recovery was rapid and complete.

CASE II.—Mrs. C. A. W., æt. 32. Fibroid polypus extending inside of cervix, firm and pear-shaped. Took out a wedge of the cervix, including attachment of pedicle, and closed with catgut sutures. No trouble after. Hæmorrhages ceased.

CASE III.—Mrs. Carrie B., æt. 33. November 3, 1898. Continuous hæmorrhages for a year past. Found vagina filled

with a firm fibrous mass, size of an orange, extending by large pedicle into uterus. After dividing the cervix the pedicle was followed up to the fundus. Here it was ligated and cut off. The uterine cavity was curetted and packed. The incision was closed with catgut. Complete recovery.

CASE IV.—Miss W., æt. 40. Complaints of continuous backache with abdominal pains, mostly right side. Metrorrhagia.

Operation September 15, 1899. After opening the abdomen the uterus was found securely adherent to the rectum and adjacent parts, probably caused by much treatment for retroversion. The uterus was dotted over with fibroids, five in number, the largest the size of a walnut. These were all enucleated and cavities closed with catgut. The adhesions having been broken up, the uterus was fixed to the superior peritonæum with two silk sutures. The ovaries were both cystic. Portions of each were removed. The appendix not being in good shape, looking red and distinctly catarrhal, it was removed. The peritonæum was closed with catgut, the muscular sheaths brought together with chromicised gut, and the skin by one long, buried silk suture. Is now practically well.

CASE V.—Mrs. McD., æt. 34. Married at 14. No children. Has had several severe attacks of pelvic inflammation. Headaches, backaches, bearing down, and altogether unable to work.

October 6, 1899, operation by abdominal incision. There was found a large fibro-cystic tumor in right broad ligament crowding the uterus back. Over the top of this and adherent to it was a greatly-enlarged and elongated appendix. Both ovaries contained cysts, and the uterus was adherent and immovable; in fact there were pretty general adhesions. The tumor and right ovary were removed, and a portion of the left ovary. A small fibroid on posterior wall of the uterus was also removed, and the uterus fixed to the abdominal wall with silk sutures. The appendix was also removed. The wound was closed as above. Pus developed in the wound, but the case is well on to recovery.

CASE VI.—Mrs. H. I. F., æt. 40. Continuous metrorrhagia nearly a year. Much backache and pelvic pressure. Poor digestion and anæmia. Examination showed the pelvis filled with a globular mass nearly obliterating the cervix. Diagnosis: intramural fibroids.

Operation March 7, 1899. Abdomen was opened and few adhesions found. A multilocular mass found which included the uterus, lying deep in the pelvis. Hysterectomy. The cervix was divided by a wedge-shaped incision and closed over with layers of catgut sutures. The abdomen was closed with silkworm-gut and healed without pus. Recovery good and complete.

CASE VII.—Mrs. Amanda K., æt. 40. Was very weak and anæmic from loss of blood and much suffering. Diagnosis: Uterine fibroma size of foetal head, low in the pelvis. This tumor was developed in posterior uterine wall. Hysterectomy was made, leaving the cervix, which was treated as in Case VI., intraperitoneally. The recovery was slow but complete.

CASE VIII.—Mrs. Mary B., æt. 39 (colored). Complains of much abdominal "misery." Thinks she may be pregnant. One can easily feel multilocular mass or masses in abdomen.

Operation October 30, 1897. On opening the abdomen about fifteen nodules were found in and attached to the uterus, all of a fibrous character. This mass, with the uterus, was removed entire. It was found that the uterus contained a two months' foetus. Recovery rapid and good.

CASE IX.—Miss Anna W., æt. 36. Large abdominal tumor been growing six or seven years. Is nearly worn out by continuous flooding and pain. Heart feeble and irregular. On opening the abdomen an irregular-shaped mass presented, well down into the pelvis and up to the diaphragm (weight 18 pounds). Many adhesions and no pedicle. With great difficulty it was separated from its moorings, and removal effected, down to the vaginal tube. Sufficient peritonæum was saved to reline the pelvic cavity, and a small opening was left into the vagina. Recovery was necessarily slow, but her health has since been better than for years.

CASE X.—Mrs. A. F. M., æt. 44. Supposed she was pregnant and near term. No flooding. Large rounded tumor filling abdomen to umbilicus.

Operation October 3, 1898. The tumor seemed to embody the uterus in its mass, was without pedicle, and required removal to the vaginal walls. The peritonæum was united to edge of vaginal wall, and the opening nearly closed. The recovery rapid and good.

CASE XI.—Mrs. D. R. II., æt. 30. No children. For several months menses irregular, painful and profuse. Found a large round tumor of the lower abdomen, extending low into the pelvis, and entirely fixed. Much pressure on rectum and bladder.

Operation October 1, 1898. Opening the abdomen a large lobular mass presented, with universal adhesions. It so entirely filled the pelvis, and was so immovable, that I decided not to attempt to dislodge it. I therefore removed both ovaries and tubes and closed the abdomen. The recovery was rapid and without incident. Her husband, a physician, reports her health as perfect, and the tumor so reduced in size that all discomfort is gone.

CASE XII.—In a case very similar to the above, in a young unmarried woman (Miss M. C., æt. 39, January 7, 1896), the conditions were such that I concluded not to attempt the removal of the tumor, but took out the ovaries and tubes instead. Nearly five years have elapsed, and the growth, which filled the abdomen to the umbilicus, is scarcely perceptible, and all discomfort is gone.

CASE XIII.—Mrs. L., æt. 45. Has been flooding for several months. Has been curetted and packed without avail. Very anæmic and weak.

Operation May 7, 1898. A myoma was found about the size of an orange in the anterior wall. Ovaries enlarged. Complete hysterectomy was made, followed by gradual recovery as regards health and strength. Recovered from the operation promptly.

CASE XIV.—Miss B., æt. 38. Has had metrorrhagia, with short intervals, for over a year. Abdomen large and hard. Growth extends from umbilicus to floor of pelvis. Much pressure on bladder and rectum. This tumor had many adhesions to the intestines. As there was no pedicle, the complete operation was done. Recovery was uninterrupted except for small stitch abscess. The tumor was developed in the uterine walls, and weighed fifteen pounds.

CASE XV.—Mrs. R., æt. 43. Was affected with repeated hæmorrhages, constant pelvic pains and pressure, with much backache. This tumor was the size of a child's head, and intramural. It lay deep on the floor of the pelvis, and was but slightly movable. It having dissected up the peritonæum, pro-

vision had to be made for the relining of the pelvis. Complete hysterectomy was made. When the appendix was removed, it was found to contain the historic grapeseed and a small, hard fecal concretion. In this case pus formed in the pelvis under the peritonæum, and escaped in considerable quantity per vaginum. Septic symptoms, *i.e.*, chills and fever, set in and lasted for several days, but under frequent irrigations and chin. ars. 2d the conditions gave way, and recovery is now well advanced.

I will close this running account of cases, all of which were successful, with a reference to (Case XVI. Mrs. E., operated January 27, 1898) one which, I regret to say, did not recover. I hesitated for a long time before beginning this case, and after the abdomen was opened I hesitated again, but with the hope of adding another success to the list of "inoperable cases" made the attempt. It was evident there had been much peritoneal inflammation from the fact that the adhesions were strong and universal, and the tumor, which was about the size of a large head, was firmly packed into the pelvis. The operation was slow and difficult, and accompanied with much loss of blood. During its progress the left ureter was cut, owing to its being tangled up with a mass of adhesions. This delayed the operation somewhat, but it was finally completed. The patient rallied partially, and did pretty well till the following day toward evening, when she suddenly sank as from exhaustion. A lesson this case taught me was to not be too sanguine of success always, and that there are times when it is safer to beat a retreat.

BRONCHITIS.

BY ANNA C. CLARKE, M.D., SCRANTON, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, September, 1899.)

ACUTE bronchitis constitutes nearly two-thirds of all the conditions a physician is called upon to treat in childhood. Its frequency decreases after two years of age until puberty. It is often accompanied by acute catarrh of the upper air passages. It almost invariably accompanies measles and influenza. It is common in pertussis, scarlet fever, typhoid fever, and diphtheria, and may occur in any infectious disease. It is more frequent in the cold months, but is apt to follow any sud-

den change of weather. Children inheriting weak constitutions, as shown by rickets and malnutrition, as well as those whose parents are of the hysterical order, are predisposed to such attacks. The instability of the nervous system, more particularly the vaso-motor, renders such children especially liable to catarrhal diseases when exposed to the slightest draughts. The cutaneous nerves of temperature-sense are less inured to sudden changes of atmosphere, and as a result they take cold more easily.

Among the predisposing causes may be classed organic heart trouble, hypertrophy of the bronchial glands, and obstruction to the upper air passages, which lead to mouth-breathing.

Most parents have an idea that children, especially infants, must be loaded with clothes, and as a result the skin is bathed with perspiration, and they are in the best possible condition for the slightest draught to chill the surface and congest the bronchial membranes. Too much clothing is as bad in its results as not enough. In older children the footwear should receive special attention. The shoes should be heavy enough to protect against cold and damp pavements without the use of overshoes.

As regards life, bronchitis *per se* is not a dangerous disease except in the extremes of life, and it is not the object of this paper to go into the symptomatology of the acute stage, but merely to call attention to the danger of neglecting these cases because they are not considered dangerous. Consider for a moment the structure of the lungs in early life, the low muscular development of the air-cells, and it is easily understood how it is but a step from simple bronchitis to dangerous pneumonia.

It has been my lot to treat a large number of these cases in private as well as institution work, and I have found the danger is from extension of the inflammation and the difficulty in keeping the case under observation until all the physical signs have disappeared. Especially is the latter true in private work.

The most successful treatment is that of expectancy. In mild attacks the patient should be confined to the house, and if possible to one room, so as to protect from draughts, and at the same time give free ventilation. If the temperature goes above 100.5° F. the patient should be placed in bed.

In the beginning the chest is filled with sibilant and sonorous *râles*, which are replaced in from twelve to twenty-four

hours by moist *rôles*, coarse or fine according to the size of the bronchi involved. It is impossible at this stage to tell where the disease will stop. In young and delicate infants, and more especially if the bronchitis is secondary to some other disease, it may spread very rapidly and involve the capillary bronchi. The younger the subject the more difficulty there is in clearing the tubes, and the patient is liable to die from suffocation. Death in these cases is frequently preceded by convulsions, which shows how profoundly the nervous system is shocked by the carbonic acid poison.

It is well to bear in mind that in broncho-pneumonia we are dealing with a catarrhal and not a croupous condition which undergoes resolution in from five to seven days—that we are dealing with a condition which may last one to two weeks to as many months—the patient apparently being better and worse, but not well. In fact it is not a true pneumonia, but a cutting off of a portion of the lung-tissue by a filling of the capillary bronchi with inspissated mucus. A physical examination will disclose dullness over one portion of the lungs to-day, and to-morrow that portion will be cleaned and another involved. In broncho-pneumonia the respiration and respiratory changes must be carefully watched, for the danger is from improper oxygenation of the blood, as shown by the blueness of the lips and a marble-like appearance of the cheeks. In croupous pneumonia the danger comes from the inflamed lung-tissue obstructing the blood and preventing it from completing its circuit and thus over-distending the right ventricle, and we have death from heart failure. It pays to take time and make a careful diagnosis in these cases. It simplifies the treatment. In bronchitis the first step is to reduce the viscosity of the mucus, which is poured out in such an amount as to fill the air-cells. Second, to stimulate expectoration.

As to remedies, I have found the following most useful:

Bryonia alb. 3x in the early stages and while the large bronchi are affected, dry cough, difficult breathing, flushed face and congested headache.

Ipecac. 3x will be useful in those cases where the neurotic symptoms are evident as evinced by the asthmatic breathing of small children when the mucus that is raised is swallowed, and we have the gastro-intestinal tract deranged by an extension of the catarrhal condition.

Antimonium tart. 3x is in very close relation to ipecac., only it affects the system more profoundly, and we have the great oppression and suffocating breathing, extensive mucus *râles*, but little raised with the cough; profuse sweating without relief; copious diarrhœa; the paroxysms of coughing end in vomiting; there is sopor, delirium, and, in fact, everything points to paralysis of the nerve-centres.

Kali bichrom. when the mucus is so extremely tenacious that it can be pulled out of the throat and mouth in strings. In fact I believe the potassium salts are among the best expectorants we have. I frequently use bichromate of potash, two grammes to five ounces of water in a croup-kettle. The child should always be placed under a tent, and inhalations of about fifteen to twenty minutes' duration be given from four to twelve times per day. This has given relief in the severest cases in a short time. By the way, the steam inhalation is a very effective way of administering medicines in this disease when the stomach is extremely sensitive.

Cuprum ars. 2x has saved cases for me when there was extreme exhaustion, and the breathing and cough spasmodic, and there was a tendency to convulsions.

I wish to urge the use of water in these cases; it is such a valuable aid to expectoration. When a child has a good degree of fever it will not need urging; but water should be given in liberal quantities, and, when the cough is accompanied with constant irritation in the throat, one part glycerin and two parts water will be found useful to allay the tickling and help raise the mucus.

In bronchitis local applications do little good, and, as regards flaxseed and other heavy materials so often used, I believe them to be positively detrimental. They simply add extra weight to the chest, to be lifted with every breath. To protect the chest from exposure, use a jacket of absorbent cotton covered with oiled silk.

The strength must be kept up, and in the very young this is no easy matter, as the constant coughing interferes with nursing. I recall one case in which the infant was unable to nurse except while it was taking the steam inhalations. Cacao-butter rubs have been of great assistance; and in extreme cases do not neglect rectal feeding.

Then be sure your patient entirely recovers. I think the

medical profession often neglects its duty by not showing parents the danger that often follows this disease, the tendency is so strong to consider the child well when the acute symptoms have subsided; yet we all know how common the bronchial cough is, and how it hangs on. It would not be present if nature was not endeavoring to rid the lungs of some irritant. We should remember that we have had an acute inflammation, more or less extensive, with the shedding often of large amounts of epithelium. The membrane is left raw; the secretions altered, or often destroyed. The underlying tissue may be sufficiently swollen so as to temporarily obstruct the finer bronchi. The air-cells are forced open by the labored breathing and filled with muco-purulent discharge, which becomes encysted, and prevents proper oxidation of the blood, as well as obstructing circulation and throwing extra work on the heart. It is not uncommon to find fine *râles* and areas of dullness in children several months after they have apparently recovered.

All this means a lack of nutrition to the lungs, and nature is prevented from doing the repair-work; cicatrization follows, and we have the best possible condition for future lung troubles. We cannot have so important an organ disabled and not have the entire system suffer. The nerve-balance is often lost, and asthma is the result. We all know that asthma and bronchitis form a circle, each aggravating the other. A careful examination of the lungs between the asthmatic attacks will often show the remains of an old bronchitis, and give the key to successful treatment.

The respiratory muscles become weak from disuse, and we have the flat-chested people, with a history of weak lungs and low vitality, who easily fall victims to pulmonary tuberculosis, since they present the best soil for the development of the tubercle.

The profession seems to realize the importance of the sequela of bronchitis in adults; but I fear we have not been careful enough to overcome the tendency to lung troubles in the early years. If we can bring a child to the age of puberty with sound lungs and a fully-developed breathing apparatus, we need have little fear for the future, and I believe this end can be best obtained by *curing* the bronchitis of infancy and childhood.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

MIXED DRINKS.

APROPOS of the cramming system pursued in our public schools, we would wish, this month, to protest against the teaching of physiology in them. Hygiene is a proper legitimate subject to be taught, but with the principles of physiology upon which it is based surely children have nothing, or but very little, to do. The knowledge which they are supposed to acquire is either true but far beyond their rational comprehension, and therefore worse than useless, or, if not incorrect, at least incomplete, and therefore unreliable and misleading. This is particularly the case with the teachings in regard to alcohol and its physiological importance. Indeed, the introduction of the study of physiology was the result of the activity of the so-called Temperance Movement. It was an endeavor to inculcate the principles of total abstinence by seeking to establish the uselessness and harmfulness of alcohol that led to having physiology taught in the public schools. With such an object in view, it was but reasonable to expect that only those facts would be presented which would tend to further this object. Hence, but a one-sided representation of the as yet undecided question as to the food value of alcohol is given, to the eventual detriment, we think, of the very cause it was intended to advance. It will prove harmful, because when the children, on growing up, find that incorrect statements have been made, the whole moral effect of such teachings will be lost, together with faith in other similar teachings, which may, however, be entirely worthy of their confidence.

A good cause can never be materially advanced by false, or even incomplete, arguments. The tendency of the developing mind is to accept or reject *en masse*, and later, when individual judgment begins to be exercised, it is prone to reject all, if a part has been found to be false. To this is due much of the modern skepticism, also much of the pleasure-seeking and

frivolity of which our generation is so often accused. It has been found that the truth of many doctrines is founded upon arguments which cannot stand the light of advancing science, and instead of seeking a new basis, more in accordance with our present knowledge, the truth, with the arguments which supported it, has been rejected. The sweeping condemnation of so many innocent forms of amusement in the past has been discovered to have depended either upon an entire ignorance of their true character, or upon an exaggerated importance attached to occasional abuses. When broader and more enlightened views began to prevail, the truth in regard to such amusements was not held fast, but was thrown out, together with the false assumptions upon which it had been established. Compare the opposition to the theatres and to the playing of cards, so widespread hardly more than a half-generation ago, with the amateur theatrical performances and progressive euchre parties now undertaken for the benefit of religious objects.

Although *falsus in uno, falsus in omnibus* is not an absolutely correct principle, it has at least enough truth in it to serve as a warning not to mix truths and half-truths in seeking to further a cause of any kind. We fear that more harm than good has been done to the cause of true temperance by the exaggerated statements found in our school physiologies, and from the soul-harrowing word-painting so often indulged in by advocates of total abstinence. The alleged inevitable concatenation of events leading from the cigarette through the cigar to the first glass of beer, to the perennial draughts of rum, to theft, murder and the gallows, is so often seen to be not inevitable that the possibility of its occurrence is entirely overlooked or rejected. Professor Atwater, in an address at a meeting of the New England school superintendents, forcibly drew attention to some of the misstatements found in the teachings of the school textbooks on physiology, where alcohol is treated as a poison which the body does not consume. Appealing to his own late experiments, as well as to those of others, he maintained that the truth is that alcohol received into the system is there consumed in the same way as sugar and starch, and that the energy is transformed in the case of alcohol as completely as in the case of those other articles of diet. Also that the energy yielded by alcohol is transformed into muscular energy, and that the body

gets the good of the alcohol thus transformed. Alcohol, while it does not serve to build up tissue, is nevertheless, a food, in the sense of serving as fuel for the body.

These views differ from those held by other physiologists, and just because of this difference of views we maintain that neither should be taught in the public schools. The question of temperance should never there be based upon the theoretical question as to the nature and uses of alcohol, but upon utilitarian or moral grounds. Temperance shown in presenting the evils of intemperance would go much further in preparing children to determine their own line of conduct when they shall have arrived at years of discretion, than an attempt to bias and warp their judgment in anticipation. Like the little cramped and distorted feet of the Chinese women, such distorted faculty of judgment will prove very useless when the real questions of life present themselves for individual action.

ANOTHER FAD.

“THE Pennsylvania Fish Commission yesterday notified the Board of Education that its gift to the Philadelphia elementary schools of a collection of trout eggs and mature fish for use in giving instruction in nature study will be forwarded, etc. The collection will serve a double purpose, inasmuch as the Fish Commission has long been desirous of having instruction in fish culture given in the schools, etc. To enable the teachers to use the collection to the best advantage, the Commission has directed Assistant Secretary W. E. Meehan to prepare a syllabus, which will be based on the Philadelphia system, and will comprise the eight grades in the elementary schools.” A despairing, Oh, Lord, how long? was wrung from us on reading the above.

Of course, we all recognize the inherent fitness of a Fish Commission to know what is a desirable subject of study in the public schools. If those who have had under their own eyes so many “schools” of fishes do not know what is good for schools of boys and girls, who should?

Who can fail to grasp at once the far-reaching consequences

sure to result from a knowledge of pisciculture on the part of the scholars of our public schools? We see already, in our mind's eye, the influences of this new study permeating their lives, in the school, in their homes, and in their futures, with an unctuous beneficence which in coming generations will be "as a tale that is told"—and a fish story at that.

The multiplication-table will now acquire for them an interest never before possessed. Having learned of the "stocking" of rivers with fishes, they will surely thereby learn something practical about their own stockings and those of the family. The divine command "increase and multiply," the effects of which, in the case of fishes, will have been shown, will come home to them with greater force, and the consequences of its personal application will surely be noticed in the reports of the next census. There will be no further need of inspectors in the markets, for woe betide the oily fishmonger who shall attempt to palm off an elderly porgy or a superannuated catfish upon one who knows all about fish culture. Fish being a brain food, and fresh fish a superior mental pabulum, the results on the cerebral development of the unborn descendants of those who have been taught by a glance at its teeth to tell the age of a fish, will undoubtedly be marvelous.

Want of time and space alone prevents us from following out and reproducing, as they rise unbidden before our imagination, the glorious pictures of the intensely practical results sure to flow from the teaching of pisciculture in the eight grades of our elementary schools. But our emotions overpower us, and, while closing this humble tribute to the enlightenment of our Educational Board, we would fain take time to wipe away a few tears of thankfulness, shed as an offering to an inscrutable Providence, when we think of the help and comfort and consolation which the poor lads and lasses in later years, while struggling, many for the bare necessities of life, will draw from the knowledge of embryology and pisciculture afforded them in their short school days through the liberality of our Fish Commission.

THE United States officials notified the Hahnemann Monument Committee that the ground for the Statue was staked out and the excavation for the foundation was begun March 9, 1900. Dr. H. M. Smith, the indefatigable secretary, with his singularly appropriate initials urges every subscriber to double his subscription and wipe out the deficits. Do so!

GLEANINGS.

LIGHT TO HEAL THE LUNGS.—What appears to be something in the nature of a revival of the old "blue-glass cure," which attracted a great deal of attention all over the world some years ago, is the new method of treating diseases which is now being exploited by Dr. J. Mount-Bleyer, of New York. The following description is taken from a paper recently read by him in that city:

"Pure air, sunlight and concentrated electric light will improve any case of tuberculosis. I should say the best thing a man dying of tuberculosis can do is to buy an old greenhouse, put some blue glass in the roof, and walk around naked in the sunlight. But even this treatment can be improved upon.

"I was led to my electric-light cure by my experiments on animals. Then I took men and women who had tuberculosis, and placed them in houses especially constructed with blue glass roofs; in fact, I built a solarium at Liberty, New York—a great glass building, that looks like a horticultural conservatory. My patients were drooping plants, which I attempted to nurture. They walked around in the rays of blue sunlight, and improved wonderfully. Most of them got well.

"Then, I argued, if blue light was so beneficial to consumptives, why not provide it for them artificially and in concentrated form? I procured a powerful arc-light concentrating lantern. Its candle-power must have been 10,000. I used it on my consumptive animals, sending its rays through blue glass. The effect was remarkable. The beasts were made well much more quickly than in blue sunlight. It was equally beneficial to human patients.

"Next I dispensed with the blue glass. Instead I caused the light to pass through large jars filled with chemical fluids, which absorbed all the light rays in the lower end of the spectrum, for I found that only the blue, the indigo and the violet rays exert an influence on the movement of the spores.

"If a vessel containing a deep-colored solution of ammoniated copper oxide, which transmits only blue or violet rays, be placed between the source of light and cultivated spores, the spores are seen to react, just as they will when placed in contact with ordinary white light. On the other hand, they do not react at all to light which has passed through bichromate-of-potassium solution, through the yellow vapor of a sodium flame, or through ruby or red glass. I am able, therefore, to control the reaction of spores under light rays merely by interposing various solutions in the path of light.

"Now, there is no difficulty in passing the rays through the human trunk to the lungs. We know that the cathode rays force their way through opaque bodies that ordinarily arrest the transit of sunlight. Roentgen has told us that, unlike sunlight, these cathode rays do not undulate in waves, but pass, as it were, backward and forward. To this probably is due their penetrating power. So we have the means of projecting the rays, with all their thera-

peutic properties, right into the lungs of the consumptive ; in other words, it is possible to operate on his lungs without opening his body."

Light is inimical to the development of the harmful organisms. The action of light entirely destroys the bacteria or reduces them to a condition of torpidity which they require months to overcome. A 22,000-candle-power light has been built for the doctor with which to treat persons suffering from tuberculosis.—*The Patent Record*, March, 1900.

EARLY INTUBATION IN LARYNGEAL DIPHTHERIA (Lower, Cleveland).—The advantages in favor of early intubations are—First, the child is stronger, has greater resistance, and can bear the operation better. Second, the time for the wearing of the tube is lessened, generally not requiring over 24 or 36 hours. Third, by shortening the time of wearing the tube the amount of nourishment required is less ; there is less opportunity for the introduction of septic material into the trachea, and consequently less chance of septic or broncho-pneumonia, which is nearly always the cause of death.

The indication, then, for intubation is the very beginning of laryngeal obstruction, when the breathing first becomes labored, and not to wait for the cyanotic stage, as is now generally done. The first symptom will be prolonged inspiration, slight stridor, supraclavicular retraction, and marked restlessness. Anti-toxine, if not already given, should be used at once in large doses. Nothing should be given by mouth. Rectal feeding, if necessary. Moist atmosphere. By this method we feel positive the mortality rate in laryngeal diphtheria can be greatly lessened.—*Cleveland Medical Gazette*.

Herbert P. Leopold, M.D.

DESICCATED SUPRARENAL CAPSULE IN ACUTE CORYZA (Millener, Buffalo).—He applies it to a congested condition of the nasal mucous membrane such as is present in an acute coryza. The solution is prepared by dissolving twenty grains of the dried extract in a half-ounce of water and filtering through cotton. The drug is applied, after first cleansing the nose and nasopharynx with an alkaline wash, to the nasal membrane on pledgets of cotton, and posteriorly to the naso-pharynx by means of an atomizer. In order to get the best results the solution should be made up fresh, as it will not keep in a warm room. It is possible to perform almost any operation in the nose, or on the nasal membrane, bloodlessly, by using a five per cent. solution on pledgets of wool cotton a few moments before operating.—*Buffalo Medical Journal*.

Herbert P. Leopold, M.D.

A PLEA FOR THE EXPLORATORY ABDOMINAL INCISION (Baker, Philadelphia).—In the diagnosis of abdominal conditions we are almost entirely deprived of the use of our visual sense, and to a great extent of our tactile sense also. There are not a few conditions that cannot be recognized by either the general practitioner or expert, and in these the only rational plan is to explore and accurately determine the condition. This will at least enable us to treat the case intelligently, and afford an opportunity for radical treatment that may result in a cure or greatly relieve. After substantiating his opinion by citing a number of cases, he recites his conclusions as follows :

1. Surgical cases are surgical from the beginning.
2. In obscure cases, or where there is grave doubt, our duty is to explore.
3. The sooner the operator is called in, the better. Reasons: ease of operating and increased chance for patient.—*Medical Times*.

Herbert P. Leopold, M.D.

TRAUMATIC PARALYSES OF THE SHOULDER AND ARMS.—Dr. F. Mally distinguishes between traumatism of slow and continuous action from that which is sudden and instantaneous. The former causes paralysis by compression, which is characterized by four symptoms: paresis or paralysis, paræsthesia, muscular atrophy and integrity of the electrical reaction. The muscular atrophy is very marked and early; electrical excitability is preserved both in the nerve as well as the muscle, which is atrophic, and contraction is weaker than normal. This is of great importance diagnostically. Though usually curable, yet if repeated or prolonged it may become incurable.

If the traumatism has been sudden and violent, one notes complete paralysis of the lower portion of the nerve with loss of cutaneous sensibility in that area supplied by the affected nerve. There are reactions of degeneration, rapid muscular atrophy, and histological degeneration of the nerve- and muscle-fibres. Consequently there will be, as pathological anatomy and experience teach, changes in the nerve-centres, and in these cases alterations in the anterior horns of the spinal cord. Amongst the traumatisms which act quickly and directly on the cord, and which are followed by paralysis of the shoulder and arm, are luxations of the shoulder-joint. Indeed, the forced depression of the shoulder and elevation in forced abduction, the causes of such dislocations, bring about a stretching of the nerves and a laceration of the roots of the brachial plexus, accompanied by lesions of the cord itself, as recent researches have demonstrated.

Between these two great types there are intermediate forms: partial degenerative paralyses and traumatic myelopathies. In these there are atrophies, pareses in certain groups of muscles which represent only a part of the peripheral distribution of the nerve. A rarification of the gray cells of the anterior cornua has been found, with integrity of the neighboring cells and surrounding connective tissue, and an associated rarification of the nervous elements of the motor nerve and a diminution of the number of muscular fibres, the single elements having retained their normal volume.

Reflex Paralyses.—These differ from secondary reflex paralyses following certain traumatisms of the shoulder, especially traumatic scapulo-humeral arthritis, for the muscles involved are not exclusively the extensors, especially the deltoid, and as spastic phenomena are lacking. Finally, hysteric post-traumatic paralyses should not be forgotten. Traumatic neuritis is either rapidly cured or the reactions of degeneration are present from the beginning, or a sort of intermediate form is met with, which is peculiar to all diseases of the cord—anterior poliomyelitis, progressive muscular atrophy, etc.; hence, clinically, as certain injuries affect the cord itself by laceration of the nerve-fibres, he proposes calling them traumatic myelopathies.—*La Settimana Medica*, No. 44, 1899.

Frank H. Pritchard, M.D.

INDICATIONS FOR THE USE OF CLIMATE IN TUBERCULOSIS.—Williams (*Med. Times*, Dec., 1899) quotes from the paper read by Weber before the International Tuberculosis Congress, at Berlin, in which the following indications were given:

1. In cases with limited disease at one or both apices, without or with only a slight amount of fever, nearly all climates can be made use of, but especially high altitudes and sea voyages, if the constitution is a strong one.
2. Cases with limited local disease and high fever must be at first treated in their houses or immediate neighborhood.

3. In the majority of cases with extensive disease of one or both lungs, without fever or with only slight fever, treatment at only a moderate elevation or at warm seaside localities deserves the preference.

4. In advanced disease with fever, neighboring health resorts, with careful supervision, should be recommended.

5. In cases of progressive tuberculosis, with scattered foci in both lungs and much fever, localities near home, or the home itself, are the best places.

6. In cases of chronic, slowly progressive phthisis, better results are obtained from warm winter resorts, or sometimes from sea voyages.

7. Quiescent cases with extensive damage or cicatrization are generally better off at only slight elevations.

8. Cases with albuminuria, without fever, should avoid high altitudes.

9. The complication of moderate diabetes does not exclude high altitudes, but the latter are injurious in cases with advanced diabetes and emaciation.

10. Chronic cases, with much catarrh, require places with as little wind as possible.

11. High altitudes are contra-indicated in chronic cases with extensive emphysema.

12. For the prevention of scrofula and tuberculosis, all healthful climates can be used, but high altitudes have advantages against tuberculosis, and marine climates (including sea voyages) more against scrofula.

13. The cure of tuberculosis during the early stages is possible in all climates. But climate itself, without careful medical supervision, is generally insufficient. The patient's blind reliance on the climate often leads to errors, to aggravation of the disease, and to death. For the majority of patients, therefore, treatment in sanatoria should be preferred, but for the treatment of the poor it is a necessity. The erection of numerous sanatoria for the people is, therefore, a national requirement for the cure, the prevention and extermination of tuberculosis.

Woodward D. Carter, M.D.

INDICATIONS FOR SURGICAL INTERVENTION IN CHOLELITHIASIS.—Macdonald, of Washington, has formulated the following indications for operation:

1. When the attack is progressive.

2. When there are severe and repeated attacks.

3. When faceted stones have been passed, and the patient has relapses rather than recurrences.

4. When there is persistent gastric disturbance and persistent tenderness over the gall-bladder between attacks.

5. When there is impaction.

6. When the patient is incapacitated by reason of frequently recurring chills and hyperpyrexia with alarming gastric and constitutional symptoms.

7. When there is jaundice dating from an attack.

8. In all cases where medicines and general treatment fail to give relief.—*Med. Century*, February 1, 1900.

F. Mortimer Lawrence, M.D.

EFFECTS OF INTRACEREBRAL AND SUBCUTANEOUS ADMINISTRATION OF TETANIC ANTITOXIN IN TETANUS, AS OBSERVED IN NINE CASES.—Abbe (New York) says, "The disease, as generally considered by surgeons, is rightly regarded as one of the most formidable maladies one has to treat, yet occasional writers rate the general mortality as low as 50 per cent. Under the best forms

of treatment, most writers, however, regard 80 per cent. as more nearly correct."

The author reports nine cases, subjected to serum treatment, with varying results. The first case, treated with subcutaneous injections of anti-tetanic serum, chloral, bromide and morphine, died in eight days. The antitoxin seemed at first to have some control of the spasm, but failed afterwards to show an appreciable value. The second case resulted fatally in three days. Here also antitoxin was used subcutaneously and in moderate quantity. The case, however, was grave from the start. In the third case one injection of twenty cubic centimeters of antitoxin was given, which did not seem to have much if any influence on the spasms, the boy dying on the third day.

Intracerebral injections of serum were used in the next two cases. One recovered, and one died. The injections in the favorable case were made at the back of the fissure of Rolando, two inches from the median line. The needle was introduced one inch into the brain substance, injecting three cubic centimetres on each side. Twenty cubic centimeters were also given subcutaneously. Sixteen hours later another cerebral injection was given, with a subcutaneous injection of twenty cubic centimeters every six hours up to the end of forty-eight hours. The dose was then cut down to ten cubic centimeters. In all, he received for the first ten days from fifty to sixty cubic centimeters of antitoxin daily. On the nineteenth day there was marked improvement, and convalescence progressed favorably thereafter; spasmodic contraction of hand remained for about six weeks.

Case VI., though presenting a milder type, was arrested at its progressive stage by serum, given hypodermically, and retrograded slightly on stopping medication; improvement being resumed when it was again administered.

Case VII. was subjected to the intracerebral injections, and recovered. It illustrated slight improvement at once after treatment, and complete arrest of rapidly progressing tetanus, the disease beginning on the ninth day after injury, and promising to be of a severe type unless arrested by treatment. The trephining was easily done by the aid of cocaine.

Case VIII. presented no appreciable benefit from the antitoxin treatment, dying some thirty-six hours after an intercerebral injection. This case was one of the gravest types of the disease brought under care at a late stage.

Case IX. made a good recovery under the combined intercerebral and subcutaneous treatment with serum. The operation was done on the third day of the disease (twenty-second day of the accident), under chloroform anæsthesia: six centimeters of serum were injected into the brain, one-half on each side. Three weeks after the operation the patient was absolutely well, excepting a slight rigidity of ankle (the seat of infection).

In conclusion, the author points out the value of the serum treatment in this grave malady, and also urges an extended trial and further study of the cerebral injections, in preference to the subcutaneous method.—*Annals of Surgery*, March, 1900.

Gustave A. Van Lennep, M.D.

FRACTURE OF THE PATELLA.—Bissell (New York) reports a case of successful bony union by open operation, seven months after fracture. The patient was in poor physical condition, being anæmic, with a well-marked locomotor ataxia, and the subject of a previous operation for pyonephrosis.

The union was fibrous, with a separation of two inches. The fragments were exposed by a transverse incision, dissected free, and approximated, with great difficulty, by means of a silver-wire suture. Seven days later it was found that the wire had broken under the extreme tension, and the fragments had separated one inch and a half. A second operation was undertaken and the fragments rewired, after releasing them more thoroughly. The ultimate result was good, bony union being obtained, and the patella freely movable upon the joint-surface. This case is interesting in that it goes to prove the value of the open operation in fracture of the patella.—*New York Medical Journal*, February, 1900.

Gustave A. Van Lennep, M.D.

A TREATMENT FOR ACUTE SEROUS SYNOVITIS PERMITTING OF JOINT FUNCTIONS.—Hoffman (St. Louis) suggests a modification in the use of the adhesive-plaster treatment for this condition, which he has found to give good results. He terms it the *compression treatment*. "The principle is to fill all depressions about the joint with cotton, and then to apply strips of rubber adhesive plaster in such a way as to *entirely encircle* the joint and several inches of the limb above and below it, so as to make firm and equable compression. The joint in which it has been found to be of the greatest value, and in which the results, both immediate and permanent, are truly remarkable, is the knee. This, moreover, is the joint by far most commonly affected by acute serous synovitis, whether produced by injury, exposure to wet or cold, overexertion, or some indefinite cause."

The author has used this treatment in one hundred and fifty-six cases of synovitis, with most gratifying results. It is applicable not only to the knee, but to the ankle, elbow and wrist. In the upper extremity there is more tendency to swelling below the dressing, and the part should therefore be supported by a bandage to the point where the plaster compression begins. As a rule, immediately after the application of the dressing, patients are permitted to use the limb in any way that does not cause pain or discomfort.—*New York Medical Journal*, January, 1900.

Gustave A. Van Lennep, M.D.

REPORT OF A CASE OF RECOVERY AFTER GASTRECTOMY FOR CARCINOMA.—Harvie (New York) reports another successful gastrectomy. The patient was a woman, 46 years of age. The median incision was used, and the organ, which was generally adherent to the surrounding structures, removed with about three centimeters of the duodenum. The œsophagus was united to the duodenum with a Czerney-Lembert suture. The abdominal wound was closed. There was very little loss of blood, but profound shock, requiring "transfusion." The entire time of the operation was one hour and five minutes. An examination of the removed organ showed a carcinoma, originating in the floor of an old ulcer, with metastases to the omental glands.

The after-treatment consisted mainly of rectal feeding for the first week. The seventh day after the operation food was given by the mouth—beef-tea, milk, and water, 1 ounce alternately every two hours. Later, milk-toast, poached eggs and coffee were added to the diet list. The patient left the hospital on the forty-fourth day after taking a dinner consisting of roast beef, mashed potatoes, ice-cream, cup of coffee, and one glass of milk. A few days later she reported a gain of 21 pounds in weight since the operation. "Her appearance was one of happiness, and her feelings those of perfect

comfort, every vestige of stomach distress having vanished."—*Annals of Surgery*, March, 1900.

Gustave A. Van Lennep, M.D.

A NEW METHOD OF SUTURE IN OPERATIONS FOR INGUINAL AND OTHER FORMS OF HERNIA.—Leonard Freeman (Denver) makes use of an entirely new method of suture, which not only approximates more thoroughly the edges of the inguinal canal, but allows of the use of non-absorbable material, which is removed easily, when healing is complete. "Previous to the operation, two or three needles are threaded with long loops of silkworm gut," silver wire, or silk. Both ends of the suture are passed through the eye of the needle, thus forming a loop. "Two long pieces of stiff silvered wire are procured, long enough to reach the entire length of the inguinal canal, out through the external ring and beyond the surface of the skin (small probes answer the purpose well)."

The sac is treated in the usual manner, and the cord held out of the way, as in Bassini's operation. "One of the silkworm-gut loops is passed from without inward through the muscular tissue on the umbilical side of the ring, well back from the margin, and fairly close to the point of exit of the spermatic cord. The loop is then carried through Poupart's ligament from within outwards, some distance from its free edge. A loop is similarly inserted near the pubic limits of the opening. One of the previously prepared wires is now run through the loops, which are pulled tight enough to hold it in place. The other wire is laid along Poupart's ligament between the free ends of the loops, which are firmly tied over it, thus approximating the wires and bunching a quantity of muscular tissue against the ligament. Before finally inserting the wires, they should have been bent upwards at their pubic extremities, so as to protrude through the external incision, thus facilitating their removal. The ends of the wires furthest from the pubes must be so placed that they leave the new internal ring neither too large nor too small."

The cord is then dropped in place over the line of union, and the remainder of the operation done according to the method laid down by Bassini. The upturned ends of the wires are allowed to protrude through the lower angle of the wound, and the free ends of the silkworm-gut loops are brought out through the skin, between the stitches. In from ten days to two weeks the wires are removed. This releases the loops, which are also extracted.

This method should find a large field of usefulness in cases of umbilical or ventral herniæ, where the opening is large, and tension correspondingly great.—*Annals of Surgery*, March, 1900.

Gustave A. Van Lennep, M.D.

A CASE OF TRAUMATIC VARIX OF THE ORBIT IN WHICH LIGATION OF THE LEFT COMMON CAROTID ARTERY WAS SUCCESSFULLY PERFORMED.—Oliver (Philadelphia) reports a case of traumatic varix of the orbit successfully treated by ligation of the common carotid. The patient, a man twenty-seven years old, was struck on the left eye, five days previously. There was marked swelling of the lids, chemosis of the ocular conjunctiva, protrusion forward of the eyeball, no movement of the globe or iris. In the temporal region a marked bruit could be plainly recognized by direct auscultation, which was synchronous with the radial pulse. Vision was reduced to one-eighth. Ligation of the common carotid was performed about a month later, the artery being tied by a treble ligature after the manner suggested by Ballance and

Edmunds. This was followed by an entire cessation of the pulsation and the bruit, the eye settling back into the orbit. It took several weeks for the swelling of the lids and conjunctiva to disappear. Five months after the operation the eye presented all the appearances of absolute secondary glaucoma.—*The American Journal of the Medical Sciences*, March, 1900.

Gustave A. Van Lennep, M.D.

THE TREATMENT AFTER LAPAROTOMY—(Fritsch).—The termination of the case does not depend wholly on the fact that infectious material has or has not been introduced into the abdominal cavity. Absolute sterility during the operation is neither possible nor necessary. There are many factors, especially good operating, which tend decidedly toward a good result. If the outcome of the operation depends alone on the introduction of infectious material, the after treatment is superfluous.

The preparation of the patient should not lead to weakening of the organism. The patient should be allowed to eat the day before the operation for psychological reasons, but the stomach and intestines must not be overloaded. Excessive purgation with salts is not advisable. We are not so helpless after operation as has been thought. There are many so-called septic cases which can be saved. Fever is not to be relied on altogether for prognosis, but the pulse is of great importance. Danger does not come with a stroke, but in hours and days in which something can be done to strengthen the patient and to save her. She should have absolute quiet. The excitement of visitors robs her of sleep and rest and tends to produce vomiting, and thus directly endangers life. There should be in all cases of long-lasting or severe laparotomies, especially if there has been a considerable loss of blood, an immediate subcutaneous infusion of warm saline solution before applying the dressings. One should not wait for severe symptoms, but anticipate them. The foot of the bed should be raised and an enema given every two hours of 60 g. of warm water with a little brandy. If the pulse is weak, give an injection of oil of camphor every two hours. Fritsch has used it for twenty-four hours and longer with good results and never has seen any harm from it. The patient must be well warmed. The writer has conducted hot air from a spirit-lamp through a lead pipe beneath the bedclothes to the patient. The stomach must be kept empty for twenty-four hours. He does not consider cathartics necessary. A healthy bowel will have peristaltic action in spite of extensive adhesions, and an infected, infiltrated intestine will not move, whether it is adherent or not. Vigorous action of the heart promotes normal resorption in the peritonæum. Cocci and their culture-media are absorbed and made innocuous, the internal chemical processes become normal, and the patient has soon a better appearance. Never give up hope too soon.—*Centralblatt für Gynäkologie*, No. 40, 1899.

George R. Southwick, M.D.

A NEW METHOD FOR THE DIAGNOSIS OF TUBERCULOSIS OF THE KIDNEY—(Noble).—It consists essentially in catheterizing the ureters and collecting the urine separately in sterile bottles. The urine is then centrifugalized, and the sediment is then injected under antiseptic precautions under the skin of a guinea-pig, or into the anterior chamber of the eye. If the kidney is tuberculous, the guinea-pig will develop tuberculosis in four or six weeks. It is a very delicate test, and it is the most reliable single procedure yet devised.—*The American Gynecological and Obstetrical Journal*, December, 1899.

George R. Southwick, M.D.

THE EARLY USE OF PURGATIVES AFTER ABDOMINAL SECTION—(Ramsey).—The writer made a careful study of the subject in the wards of the Johns Hopkins Hospitals, and summarizes his conclusions as follows :

1. It is important, both for the welfare of the patient and for the comfort of the operator, to attend carefully to the diet and to the thorough emptying of the bowel before any abdominal operation.

2. The bowels should be moved, and the distention relieved soon after the operation, both for the comfort of the patient as well as to avoid possible dangerous complications.

3. In the simpler groups of operations, such as suspension of the uterus, myomectomies, the removal of uncomplicated ovarian tumors, and in uncomplicated hysterectomies, the administration of the calomel and the use of enemata on the second day is followed by a perfectly satisfactory convalescence.

4. In cases of beginning peritonitis, in cases where numerous adhesions have been broken up or large areas left raw, in cases where the intestines have been freely handled or long exposed, and, finally, in emergency operations where no previous preparation can be made, Dr. Byford's method of immediate purgation by drachm doses of Epsom salts every hour for six doses as soon as the patient recovers from the anæsthetic, and an enema repeated till the bowels move, is indicated.—*American Journal of Obstetrics*, 1899.

George R. Southwick, M.D.

THE BACTERIAL EXAMINATION OF THE BLOOD IN ECLAMPSIA—(Levinowitsch).—Most recent authors have been outspoken against the bacterial origin of eclampsia since the publication of Doderlein's results of his examinations for bacteria in eight cases of eclampsia. The writer has made systematic examinations of the blood in eclampsia for the past eighteen months, and gives the following summary of results :

1. The examination of fresh blood in forty-four cases of eclampsia showed constantly the presence of large cocci of round or oval shape which possessed extraordinary motility. The round forms are smaller than the oval, and should be termed planococcus (amœba).

2. The cocci are often double, and appear like diplococci.

3. The blood of eclamptics in twenty-eight cases was inoculated on bouillon, gelatin and agar. Cultures of a similar character were obtained in twenty-five of the inoculations.

4. The micrococcus grows best at the temperature of the body on culture-media derived from the placental tissues.

5. The micrococcus is stained with all aniline dyes.

6. The cultures show on the third or fourth day large oval cocci arranged in twos or fours, and are distinguished by their motion. Straining showed flagellæ.

7. Older cultures showed various involution forms, among which were rather large oval cocci, others with a central unstained portion; still others had the form of a coccus with a long, thread-like tail; and, finally, there were dumb-bell forms.

8. The cocci are found in the blood sometimes before the first attack, but usually during the convulsion, and gradually diminish in number after the second day after the attack, when involution forms are seen with a central unstained portion (spore).

9. The micrococcus is pathogenetic for guinea-pigs. They die in twenty-eight

to thirty days after subcutaneous injection of a pure culture from acute anæmia, in consequence of the existence of hæmorrhagic endometritis.

10. Slight spasms of separate groups of muscles were observed in a few non-pregnant rabbits after subcutaneous injections.

11. The same micrococcus was observed a few times in the blood of the newborn from eclamptic mothers. Two such newborn infants had eclamptic attacks.

12. The micrococcus in diminished numbers were seen in several pregnant and lying-in women who did not have eclampsia, but suffered from œdema, headache and vomiting.

13. The dumb-bell forms were sometimes seen in the cell-body of the mono- and polynuclear leucocyte in fresh blood with the aid of freshly prepared stain.

—*Centralblatt für Gynäkologie*, No. 46, 1899.

George R. Southwick, M.D.

THE TREATMENT OF GONORRHOEA WITH BREWER'S YEAST (Mensinga).—The writer has used fresh brewer's yeast for the treatment of gonorrhœa for some time with surprisingly good results. After cleansing the vagina, one or two teaspoonfuls of the yeast are painted over all the mucous membrane of the vagina and then a tampon thoroughly soaked in yeast is introduced as a vaginal tampon, and allowed to remain forty-eight hours, when it is removed, and the same treatment is repeated. The treatment is continued during menstruation, and then the tampons are allowed to remain only twenty-four hours. The writer has never seen an injurious effect, and the disease has been cured much more rapidly than by the usual methods of treatment.—*Centrallblatt für Gynäkologie*, No. 48, 1898.

George R. Southwick, M.D.

STYPTICIN IN THE TREATMENT OF UTERINE HÆMORRHAGE (Nassauer).—Stypticin is an alkaloid of opium. It is especially indicated for those hæmorrhages which do not depend on pathological alterations of the endometrium. It appears to act on the vaso-motor nerves of the genital tract and not to cause contraction of the uterine muscle like secale. It has given excellent results in menorrhagia, metrorrhagia, in reflex hæmorrhages, and in pure climacteric hæmorrhages. It is given in aqueous solutions hypodermically of 0.2 gram or 2 c.c. of a 10 per cent. solution, which acts at once, or internally in tablet form, each tablet containing 0.05 gram: two tablets four to six times a day.—*Monatsschrift für Geburtschulfe und Gynäkologie*, 1899.

George R. Southwick, M.D.

DRAINAGE AND PERITONITIS (Sippel).—The peritoneum does not possess the extreme sensitiveness to infectious material which was formerly ascribed to it. On the contrary, it has far greater resistance than any other tissue of the body. It can render harmless relatively large quantities of infectious material.

This protective power of the peritoneum depends partly on its great power of absorption and partly on the action of the peritoneum itself, which may depend on the endothelium, or any irritation that causes a very active diapedesis of leucocytes.

This protective power ceases if large quantities of fluid saturated with infectious material reaches the peritoneum and when absorption of infectious masses is impossible, such as blood coagula or particles of dead tissue; also, if the action of the peritoneum is disturbed by external causes. The mere con-

tact of the peritoneum with atmospheric air is sufficient to inhibit the protective power of the peritoneum.

The introduction of toxine with the bacteria may diminish or destroy the protective power of the peritoneum.

There are bacteria so virulent that the peritoneum cannot overcome them.

If we apply practically the above facts, which have been determined experimentally, we find that not every soiling of the peritoneum with pathogenic fission fungi leads to peritonitis. If their virulence is not so extreme that no living tissue can resist them, the occurrence or non-occurrence of peritonitis depends on whether the quantity of bacteria introduced is not too large, that a minimum amount of toxine is introduced with them, that the peritoneum retains its normal conditions, that fluid does not remain in the peritoneal cavity, or collect subsequently to serve for a culture medium for such germs and to increase their growth and toxine to such an extent as to destroy the protective power of the peritoneum. We therefore protect the peritoneum by the use of physiological salt solution. By irrigation with it, and without the least harm to the peritoneum, we diminish the number of bacteria, dilute the toxins, and remove the albuminous fluids which are liable to degenerate. Properly arranged drainage will conduct away any further collection of fluid, bacteria or toxins. A stiff or non-collapsible drainage tube of sufficient size to hold an iodoform wick without compressing it is introduced through the abdominal wound, and a gauze compress applied thick enough to absorb the fluid removed by capillary drainage.—*Monatsschrift für Geburtshülfe und Gynäkologie*, 1899.

George R. Southwick, M.D.

CONSERVATIVE GYNÆCOLOGY.—Massey, Philadelphia, says: Leaving aside ovarian and dermoidal tumors, purulent collections, malignant conditions and fibroid tumors, also conditions requiring plastic work, the vast majority of the remaining affections peculiar to women are more or less amenable to treatment without recourse to the knife. He denounces the use of the sharp curette. The steel dilator he terms a barbarous instrument to employ in a cervix which is not physiologically prepared to dilate. Its use often leads to peri-uterine inflammation. Of pessaries, he declares he has not placed one in position for years, except in cases of strictly senile relaxation.

He treats post-inflammatory, catarrhal and congestive conditions by the use of vaginal applications of hot water, glycerine, iodine, ichthyol, etc. Finally, should these prove unsuccessful, he resorts to electricity, the galvanic current being applied to both the vagina and uterus.—*N. Y. Gynecology, and Obst. Journal*, February, 1900.

W. D. Carter, M.D.

NOTES ON CANCER.—John C. MacEvitt, M.D., Brooklyn, N. Y., summarizes his observations. He is doubtful if cancer of the uterus is more prevalent at the present time than in past periods, though its recognition is more general. Too little attention is paid to its genesis. Its early recognition is difficult, and can only be discovered through the use of the microscope. It is generally in an advanced stage when referred to the surgeon for treatment. A clinical division of such processes should be adopted. The following division should meet all requirements:

Primary, or stage of incipency; secondary, or stage of infiltration; tertiary, or stage of lymphatic infection; quaternary, or stage of adnexal and systemic infection.

The selection of surgical measures depends upon the stage of the disease. The high amputation by galvano cautery is the best method when the infection is confined to the cervix. When the disease is confined to the uterus, or with but slight encroachment beyond, hysterectomy is called for; when all the pelvic organs are involved, it is better to adopt palliative measures only.—*N. Y. Gynec. and Obst. Journal*, February, 1900.

W. D. Carter, M.D.

ACUTE INVERSION OF THE UTERUS.—A. Laphorn Smith, London, Eng., has, in twenty-five years' practice, been concerned in but three of these cases. He states that the condition is rare. It was met with in the Rotunda Hospital but once in 190,000 deliveries, and in the Vienna Lying-in Hospital 250,000 deliveries occurred without a single case.

His first case relates to a patient who had been etherized and delivered by forceps, the child being born with the cord twice wrapped around its neck. The cord was followed immediately by the fundus of the uterus, with the adherent placenta. This was detached from the uterus amidst frightful hemorrhage. An attempt was made to restore the uterus, but profound collapse ensued, the patient dying.

The second case was one of chronic inversion, the condition being present for several years. An attempt was made to push the fundus up through the vagina, but was unsuccessful. The abdomen was then opened, and a strong cord was passed through the cervix, fundus, and vagina. A metal button was then attached and an attempt made to draw the fundus through the cervix. This was finally accomplished, but not without tearing the cervix. The latter was sutured. The woman succumbed.

The third case: The mother was delivered with forceps and the placenta removed after much difficulty, it being necessary to deliver manually. The attending physician did not return until the sixth day. The patient then complained of "something coming from her." Upon examination a lump was found protruding from the vagina. She had a temperature of 101°, pulse 140, a state of mild collapse, also a profuse discharge from the vagina, emitting a horrible odor. Under ether anæsthesia the inverted uterus was gradually replaced by making pressure about the cervical portion, first with one finger in the right cornu, then by making a cone of the whole hand and exerting pressure. The patient recovered.—*American Gyn. and Obst. Journal*, January, 1900.

W. D. Carter, M.D.

A NEW METHOD OF TREATING PROLAPSE OF THE UTERUS AND BLADDER.—Stone, Washington, D. C., remarks that the frequent failures attending the repair of cystocele is due to misdirected effort. The hernia is not due primarily to an overstretching of the anterior vaginal mucous membrane, but to the lax condition of the intercellular tissue between the posterior bladder-wall and the vagina and uterus. To overcome this difficulty he has adopted the following method of operation: The crescentic incision is made over the cervix, as in beginning vaginal hysterectomy. The bladder is widely separated from the uterus and broad ligaments, and the edge of the incised vagina sutured to the anterior surface of the uterus as high as the insertion of the round ligaments, if possible. The raw surface of the uterus is now covered, as well as may be, by drawing the lateral edges of the incision over it. By this method the

"slack" of the vaginal cystocle can nearly all be taken up. The abdomen is then opened and the bladder or its uterine reflexure is sutured to the fundus of the uterus, taking the precaution to scarify the surfaces before suturing.

In women who may never again become pregnant the fundus is brought into direct contact with the rectus muscle and sutured.—*American Gyn. and Obst. Journal*, January, 1900.

W. D. Carter, M.D.

THE RANK OF CÆSARIAN SECTION, SYMPHYSEOTOMY, PREMATURE LABOR AND VERSION COMPARED.—J. H. Benyon, M.D., Newark, N. J., presents the following conclusions:

(1) That the absolute indications for Cæsarion section are tumors in the genital canal, osteomalacic deformities, cicatrices and contractions of the vagina, rupture of the uterus, women dying near the end of pregnancy, irreducible impaction of a living child in transverse presentations, and pelvis with a live child and a conjugate diameter of 4.5 to 5.5 centimeters.

(2) That the indication for Cæsarion section is relative, and competes with craniotomy in a pelvis with a live child and a conjugate of 5.5 to 6.5 centimeters, and in a generally contracted pelvis of 7 to 7.5 centimeters or less, but displaces craniotomy only when subject to the indorsement or demand of one or both parents.

(3) That the indication for craniotomy is absolute when the child is dead and the conjugate measures 4.5 centimeters and upward.

(4) That symphyseotomy competes with and *always displaces* the relative indication of Cæsarion section in a pelvis with a conjugate of 7 centimeters or more, and sometimes if the head is small in a pelvis with a conjugate of 6.5 centimeters or more.

(5) That symphyseotomy never competes with premature labor in pelvis measuring 7 centimeters or more, and displaces it only when expressly and absolutely demanded by the mother, but under no circumstances does it displace premature labor when the conjugate measures less than 7 centimeters.

(6) That symphyseotomy may be viewed as an aid to premature labor when the head is too large to engage.

(7) That symphyseotomy rarely, if ever, competes with version or forceps in pelvis when the conjugate measures 8.5 to 9.5 centimeters.

(8) That Cæsarion section, symphyseotomy, premature labor, craniotomy, version and forceps all have a definite place and relation in obstetrical operations, the success of which will, of course, always depend upon the acumen, skill and care of the accoucheur.—*New York Medical Times*, March, 1900.

W. D. Carter, M.D.

A CASE OF ODONTALGIA DEPENDENT UPON INSUFFICIENCY OF THE INTERNAL RECTI-MUSCLES.—In describing this case Neuschüler lays stress upon the fact that owing to the obscure origin of such cases they are frequently overlooked, and consequently are not as rare as is generally supposed; when discovered, it is usually by accident. The author's patient, who was a medical student, noticed that after prolonged application of his eyes for near work he suffered from a pain in the orbit, which would finally spread to the teeth and become so severe as to necessitate a cessation of close work. Glasses had failed to relieve the trouble.

The eye-grounds were found to be normal, the right eye being emmetropic.

The left one was myopic to the extent of one and one-quarter diopters. There was a tendency for the eyes to waver when they were fixed upon a near object. Prisms of two degrees strength, bases in, were ordered for close work, with the result that the dental pain was relieved.—Neuschüler, Turin, *Rescueil d'Ophthalmologie*.

Wm. Spencer, M.D.

SURGICAL DISEASES OF THE FAUCIAL TONSILS.—A review of the subject in which the following points are emphasized: The anatomic construction of the supratonsillar fossa and its liability to retain secretions in the lacunæ. As the lacunæ are largely out of sight they may be easily overlooked, and an insufficient amount of trouble be found to account for the symptoms complained of. Small tonsils with obstructed lacunæ may be more troublesome than much larger ones with wider open crypts. Cartilaginous or bony deposits in the tonsil are probably of congenital origin. There is a form of paroxysmal cough which has its origin in a pathologic condition of the tonsil, operating reflexly through the pneumogastric, and a case history is given which evidences this. A young woman had a persistent hacking cough, evidently reflex. Careful examination failed to find its cause until a probe touched a point in the right tonsil, irritation of which produced a paroxysm of coughing. Repeated tests confirmed this, although the tonsil was small and apparently not troublesome. Removal of the tonsil cured the cough.—T. M. Strong, *N. Y. Med. Gazette*.

Wm. Spencer, M.D.

ACCESSORY THYROID TUMORS AT THE BASE OF THE TONGUE.—The author records a case of accessory thyroid occurring in a woman of 25, who was anæmic, and complained of insomnia and gastric derangement. Although 133 pounds in weight she was poorly nourished, and evidences of nervous exhaustion were marked. At the base of the tongue was a tumor the size of an English walnut, covered with mucous membrane, intensely vascular, and at times almost entirely filling the fauces. During the menstrual period it was larger and more vascular. It was hard and immovable to the touch; there was no pain; speech was thick and non-resonant; the larynx and epiglottis were normal. Electrolysis reduced the size of the tumor somewhat, but was followed frequently by considerable hæmorrhage. The patient was operated by a median incision from the symphysis menti to the hyoid bone, the muscles of the base of the tongue were pushed aside and the tumor enucleated. Microscopically it was found to be a ductless gland of the thyroid type—an accessory thyroid.—Dr. Jacob E. Schadle, *Jour. Amer. Med. Assn.*

Wm. Spencer, M.D.

BLINDNESS AS A RESULT OF TABES DORSALIS.—The eyes of 101 cases of tabes and the optic nerves of 12 cases were examined histologically. The first stage, with good central vision, can remain for a long time; in the second stage, however, the vision decreases rapidly. The affection is of a progressive nature, and leads always to blindness.

The peripheric limitation of the field of vision and the difference existing between both eyes indicate that the main seat of the affection is to be found in the part of the optic nerve which lies in front of the decussation. In view of this fact, the atrophy (histologically) decreases as we go upward from the eye, and he succeeded in demonstrating that the marginal nerve-fibres showed the highest degree of atrophy.

According to Grosz, the origin of the affection of the optic nerve is to be found in the ganglionic layer, and the atrophy of the optic nerve is a symptom co-ordinate with the change in the spinal cord ; the same poison which causes degeneration of the central nervous system causes also the degeneration of the optic nerve. The poison is transmitted by the blood-vessels, and all the symptoms indicate that syphilis plays, directly or indirectly, the main part in the causation.—Prof. W. Schluck, *Ung. Medicin. Presse*.

Wm. Spencer, M.D.

THE ABUSE OF COCAINE BY OPHTHALMOLOGISTS.—According to a member of the editorial staff of the *Southwestern Medical Record*, physicians forget the injurious local effects of cocaine upon the nutrition of the cornea. In cases where it has to be applied for a considerable time, as in conjunctivitis, corneal ulcers, and other forms of eye-pain due to inflammation, it becomes quite hazardous.

The practice is common of general practitioners prescribing a solution of cocaine for eye-pains. When used thus for any considerable period of time it causes dryness of the cornea and looseness of the epithelium, this increasing the pathological conditions of corneal ulcer. Normally, corneal circulation is small, and, therefore, to inhibit for a length of time its action is to decrease the vitality of corneal tissue. Its application deceives the physician by creating the impression that a serious condition may be trifling, because the pain is removed. The author asserts that he has known of several cases of plastic iritis prescribed for in this way, until sufficient adhesion had taken place to bind down the iris completely in its complete circumference. For removing foreign bodies or applying silver nitrate or copper sulphate, its application is admissible, but its continued application is dangerous, and especially useless in catarrhal inflammation of the lids.—*Merck's Archives*.

Wm. Spencer, M.D.

THE ABSORPTION OF LIGHT IN TRANSPARENT YELLOW SUBSTANCES.—The writer emphasizes that the lens of an adult is yellow, and that recently yellow spectacles are recommended. It has as yet, however, not been established which light passes through yellow substances. He examined sixteen varieties of yellow glasses, and found that they shortened the spectrum ; by the examination it was shown that from the color of the medium we cannot draw a conclusion as to its absorption. The yellow glasses disturb the original, and with that the natural, equilibrium of the single parts of the spectrum.

The author recommends the eye-glasses of chamber form. We can keep from the eye the ultra-violet rays, without diminishing in the least the colored part of the spectrum, if we place in front of the eye a 2.5-mm. thick eye-glass of chamber form which is filled with trephynylanin mixed with xylol in proportion of 35 to 100.—W. Schulck, *Ung. Med. Presse*.

Wm. Spencer, M.D.

SUPRARENAL EXTRACT has been observed by Lawandowsky, when intravenously injected into cats, to cause dilatation of the pupils, retraction of the membrana nictitans, slight grades of protrusion, and raising of the eyelids—in short, all the symptoms indicative of irritation of the sympathetic ganglia of the neck. The symptoms come on very rapidly after the injections, and persist for a short time only. The action seems to be a peripheral one.—*Merck's Archives*.

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

TAKING COLD.—Dr. Michaelis calls attention to the usefulness of homœopathic remedies in the effects of taking cold. In the beginning aconite, bell. or gelsem. will regulate the circulation. If the conditions persist, and one or another organ is affected, and especially with disordered digestion, then baryta mur. 3x is indicated as a remedy of the first rank. Kali iod. 2x or 3x will restore the blood to its proper state and absorb inflammatory products in both old and recent cases. It is, besides, a preventive of the first order. Belladonna is a specific in colds of the head. In toothache from dry cold, aconite; if there be a resulting rheumatism, with wandering about of the morbid process, cham. or bryonia. Violent coryza, iodium and kali iodatum. Catarrhs complicating influenza, causticum, which is a specific. Catarrh of the pharynx and larynx, with hoarseness, kali iodatum (in a low attenuation and frequently repeated). Inflammation of the larynx, with the mucous membrane a brilliant red, digitalis or kali iodatum. Swelling of the tonsils, baryta mur. (a specific). Cough coming from the lungs, phos. Sudden aggravation of a chronic disease of the lungs, phos. acid. 2x. Catarrh of the lungs from suppression of perspiration, ipec. Gastric catarrh from cold, ant. crud. 3x. Congestion of the head from chilling, especially of the feet, aconite and bell. Suppression of the menses by cold feet, pulsatilla. Sweaty feet, the perspiration suppressed by cold, silica.—*Journal Belge D'Homœopathie*, No. 2, vol. vi. (Goodno speaks highly of gels. in acute coryza.)

Frank H. Pritchard, M.D.

CEDRON IN PERIODIC SCIATICA.—Dr. Berlin observed a maiden lady of 21 years who, for a long time a sufferer from sciatica, had received various remedies, as rhus, coloc., and gnaphalium, without much success. As she was obliged to be on her feet and to run about a great deal the improvement had not been striking. After a time the character of the pain changed; she had no pain all day, but as soon as eight o'clock in the evening struck, the pains began in the leg and lasted for two or three hours. Cedron 2x, five drops every two hours, was given. In eight days the pains had greatly decreased in severity, though in the few evenings immediately following them they were still perceptible. The patient was free from any such disturbance until the next spring, when after a cold it reappeared.—*Ibidem*. Dr. S. S. Purple has found it promptly effectual in a number of cases of intermittent fever, and believes it to possess valuable antiperiodic properties.—*New York Journal of Med.*, N. S., xiii., 173. Botanically, and in some ways therapeutically, it is allied to quassia. Puhlmann.—*Handbuch der Homœopathischen Praxis*, p. 603—states that it has been employed successfully in periodically appearing neuralgias (larvated malaria) and ciliary neuralgias.

Frank H. Pritchard, M.D.

TONGUE SYMPTOMS OF SEVERAL REMEDIES.—In the Spanish homœopathic journal, *La Revista Homœopática*, of Barcelona, the lingual symptoms of a number of important remedies are given as follows :

Apis.—Tongue a bright red, dry and covered with vesicles; the tongue trembles and comes in contact with the teeth in trying to protrude it. The margins and tip are red and covered with blisters. Swelling of the tongue in diphtheria.

Arnica.—Dry tongue, with a darkish strip in the centre (typhoid fever). A yellowish and pasty coating on the tongue (dyspepsia).

Arsenicum.—Tongue raw, red and excoriated, as well as dry; the tongue is covered with a dark-brownish and sooty coating (typhoid fever); mapped tongue (acute diseases).

Baptisia.—Tongue with a brownish strip in the centre, the borders being of a bright-red color. Tongue dark-brown and dry (typhoid fever).

Belladonna.—Dry tongue, with red tip and margins, and the centre white. The papillæ prominent and increased in volume (strawberry tongue, scarlatina); trembling of the tongue.

Borax.—Aphthæ on the tongue.

Bryonia.—White tongue or a whitish-yellow coated tongue; in typhoid fever the centre especially is whitish, and the borders are clean. Tongue dry, and looking as if scraped (typhoid fever).

Camphora.—Cold tongue.

Chelidonium.—Tongue covered with a yellowish coating which shows the marks of the teeth (diseases of the liver).

China.—Tongue heavily coated, white or dirty yellow.

Colchicum.—Tongue covered with a dirty-yellowish coating, or red, with a pasty coating at the base.

Gelsemium.—Tongue as if paralyzed (dulcamara).

Hydrastis.—Tongue broad, flabby, swollen, with viscid dirty-yellowish coat, the tongue showing the impression of the teeth. Sensation of having been scalded.

Hyoscyamus.—Tongue red, dry, fissured (bell.), with a yellowish coating.

Iodium.—Two lines of mucus or foam upon the tongue (pancreatic diseases).

Kali Bichromicum.—Thick, broad tongue, with a dirty-yellowish coating, or smooth, red and shining. The borders full of painful ulcers. Sensation of a hair at the root of the tongue.

Mercurius.—Tongue moist, flaccid, soft, spongy, swollen, and with the marks of the teeth. Painful and ulcerated tongue, covered with a dirty and yellowish coat.

Mercurius Iodatus.—Base of the tongue covered with a thick and yellow coat, while the anterior portion is red and clean (diphtheria).

Phytolacca.—Tip of the tongue very red and sensitive, with blisters on the margins. Pain in the root of the tongue on swallowing.

Pulsatilla.—A grayish-white coat on the tongue.

Rhus Toxicodendron.—Dry tongue as though slightly burnt; dark, with a triangular red portion at the tip. Tongue of a dark-brown color, fissured and bloody. Tongue smooth and red (in scarlatina).

Stramonium.—Tongue red or whitish, and dotted here and there with reddish points. A darkish-yellow coating, dry and fissured, particularly in the centre (typhoid).

Sulphur.—White tongue, with tip and borders red (acute affections). Dry tongue, with a red tip; difficulty in speaking in typhoid pneumonia.

Terebinthina.—Dry tongue, which is brilliantly red in color (typhoid fever and peritonitis); tongue smooth as though the papillæ had been scraped off.

Veratrum Viride.—A strip of bright red in the centre of the tongue (fever and meningitis).

Frank H. Pritchard, M.D.

PICRIC ACID IN ECZEMA.—Dr. MacLennan speaks highly of a solution of picric acid in water, one part to eighty-six of water, with which the (acute) eczematous surface is frequently bathed. The itching disappears at once, and there forms a protective coating under which healing rapidly follows. After a few days, when the covering falls off, a very thin yet normal-appearing skin is seen, which has newly formed. In eczema of the face and scalp of children, an obstinate affection, it renders good service.—*La Grece Medicale*, No. 11, 1899.

DISEASED STATES OF CICATRICIAL TISSUE.—Dr. Cartier, on account of the frequency of surgical operations to-day, calls attention to the possible abnormal deviations of cicatricial tissue and its treatment.

Graphites in hypertrophic development of the scar may be of service in reducing it to the normal. There may be accompanying pain or not.

Hypericum is frequently of use in painful cicatrices, and particularly indicated where a terminal nervous filament is supposed to be affected, yet not where an abscess or an effusion of blood is forming.

Belladonna is useful where the tissues surrounding the scar become painful, hot and inflamed, and especially at the beginning, but fluoric acid is indicated in old cicatrices which become red at their borders and covered or surrounded with itching vesicles. If the surrounding parts inflame, an abscess may be forming, and the remedies for suppuration should be employed; but as cicatricial tissue is without vessels and of lower vitality, suppuration may be frequently repeated.

Borax is indicated where old cicatrices reopen and ulcerate.

Carbo animalis causes lancinating pains in the cicatrices with sanious pus after opening.

Causticum is serviceable in superficial injuries which heal and open again. *Iodium* in itching scars which open, or in granulations which form around cicatrices. (Tr. iodium is an excellent remedy used as an injection to cause recent sinuses to heal.) *Kali bichrom.* is useful where the scars leave a depression after healing, if used prophylactically.

Finally, in bleeding cicatrices, *i.e.*, those which show a tendency to ooze a long time after healing, hamamelis, intus et extra, cured. Other remedies are: asafœtida, old cicatrices become black and gape open, especially in amputation stumps, with neuralgic pains. *Crotalus*, a septic element causes old scars to reopen, with an oozing of blackish blood. *Lachesis* is, in general, inferior to *crotalus*, but indicated where the cicatrix reddens, becomes painful, opens and bleeds. It is surrounded by a purple areola or numerous small granulations. *Sulphuric acid* scars which are either red, blue and painful.—*Revue Homœopathique Française*, No. 9, 1899.

Frank H. Pritchard, M.D.

KALI CARBONICUM AND ITS THERAPEUTIC ACTION.—Dr. Goullon could not practice without kali carbonicum; and particularly in diseases of females is it a valuable remedy. It resembles in many ways sepia. The periods recur too soon and are long-drawn out, similarly to acid. nitric., to which it acts complementary. Chronic leucorrhœa in girls and women before menstruation, with distressing associated symptoms; kali carb. eight days previously will usually correct them, though sepia at times is better. In the "hot flashes" of the climacteric kali carb. may be of greater advantage than sepia. When accompanied by heart symptoms, as palpitation (nervous), so that even the bed-clothing is lifted at each beat, which of course disturbs and prevents sleep. Here it and sepia are rivals. Our remedy is also to be thought of whenever the pains are stitching, or when one meets with an intermittent pulse. Three systems or organs are affected electively by kali carbonicum: the uterus, heart and lungs. In apex-catarrh one may give kali carb. in alternation with phos. If pleuritic symptoms attend with the characteristic stitching pains, then it is the more indicated. In chronic laryngeal catarrh it is often of service (sepia). In chronic affections of the knee-joints, with stitching pains. Only bryonia and silica can be compared as "knee-remedies." In stretching of the uterine ligaments, with rhus one should not forget kali carb. In hæmorrhoids, in females especially, it might be well to remember it.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 21 and 22, 1899. Dr. G. Sieffert (*l. c.*) amongst other indications mentions it in pulmonary congestion (passive) of old persons with a painful spot in the chest which moves from right to left; the chest wall is painful; cough with profuse expectoration, the cough being irritating and pertussis-like. Valvular affections of the heart; the pulse is irregular or intermittent, accelerated and weak, and this weakness is a characteristic of all the diseases in which it is indicated. Lancinating pains in the region of the heart.

Frank H. Pritchard, M.D.

MANGANUM ACETICUM.—This remedy is recommended warmly in catarrhal affections of the pharynx and larynx (3-5x). If an acute catarrh descends into the larynx with scraping sensation in the throat and a hoarse voice, then this remedy is almost specific.—*Leipziger Populære Zeitschrift fuer Homœopathie*, Nos. 21 and 22, 1899. (G. Sieffert advises manganum aceticum in chronic laryngitis, with hoarseness and expectoration of greenish mucus. Puhlmann finds it indicated in chronic laryngeal catarrh, with dull stitching pain on empty swallowing. He cites Heinigke that it is to be used in pains jumping from one joint to the other, especially in the heels, so that the patient cannot tolerate the least pressure on the heels. (Achillodynia of Albert; in such a case it might be well to suspect gonorrhœal rheumatism.)

Frank H. Pritchard, M.D.

A FEW REMEDIES IN GASTRIC ULCER.—In the *Homœopatisk Tidsskrift* of Denmark, in an article on this affection, the editor recommends treating the associated gastric catarrh with natr. mur., nux vom., puls., ars., carbo veg., sulph. or lycop. Atropine 4x is useful for the severe pains. Sulph. and arsenicum are the chief remedies to effect a radical cure. Phosphor. and arg. nitricum have a curative influence, the latter in the second or third decimal. Bismuth is serviceable more where there are so-called nervous pains in the stomach. Carbo veg. is indicated where the pains appear when the stomach is empty.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

MAY, 1900.

SLEEP.

BY W. A. SEIBERT, M.D., EASTON, PA.

(Read before the Homœopathic Medical Society of Pa., Philadelphia, September, 1899.)

WHAT is Sleep? What causes Sleep? What prevents Sleep? And, How shall the causes that prevent Sleep be removed? Four conundrums easier to propound than to answer. Let us consider them briefly seriatim.

First, What is Sleep? A most familiar affection of the nervous system that defies satisfactory explanation or definition. We know that without it we die. In early English history criminals condemned to death by being prevented from sleeping died soon in a raving insane condition. Physiologists content themselves by enumerating the physical phenomena that attend sleep when they do not, like Dalton, evade the subject entirely. They speak of the circumstances under which it occurs, the effects of it on the body, the depth of it, etc., without defining it at all. Psychologists, like physiologists, either evade a definition, description or explanation of this mystery, as does Hamilton, or they content themselves with a consideration of the mental phenomena attending it. Haven summarizes these phenomena as loss of emotional consciousness, loss of voluntary power over the body, and loss of voluntary power over the operations of the mind.

I find nowhere a presumption to define sleep any more than physicists define the article that passes over the wire to your

phone, or flashes from New York to San Francisco. Aldrich says, "What probing deep has ever solved the mystery of sleep?" As "fools rush in where angels fear to tread," the poets settle the matter of the definition of sleep by personifying it, and with this it seems we must be content. They call it "Tired nature's sweet restorer, balmy sleep;" "Death's beautiful twin brother;" "Life's nurse sent from heaven to create us anew from day to day;" "Best friend of frail humanity, and, like all other friends, best estimated in its loss."

Our *second* question, What causes Sleep? like the first, unfortunately we cannot answer with certainty. Some very plausible theories have been advanced, even in diametric opposition, by equally great men. Our own Talcott and many other authorities claim it is due to anæmia of the brain; some of the best experimenters and authorities claim it is due to hyperæmia of the brain—at least to an increased quantity of the blood in the veins of the pia mater, which exerts a certain amount of pressure on the grey matter of the brain; and the latest theorists hold that the blood-pressure is altered differently in the same case under different circumstances, and that sleep causes this phenomenon instead of resulting from it. After all, anæmia or hyperæmia probably bears the same relation to sleep that bacteria do to disease, *i.e.*, attending sleep. It does seem rather idle to investigate whether anæmia or hyperæmia causes sleep, for, on the face of it, the blood-vessels would seem rather to have been made for the brain than the brain for the blood-vessels.

Waste products, being the result of the exercise of the nervous system, are attributed by some to be the cause of sleep; and, again, the want of oxygen is another theory, and so on; but no theory—whether mechanical, dynamical or chemical—can be accepted as settling the subtle problem of the immediate cause of sleep. We know that it is a necessary phenomenon in the economy of nature, and think we can explain the need for it by fatigue, whether of body or mind or both. But, on the other hand, as if to mystify us more, those sluggish natures which allow nothing to excite or call into action the nervous system sleep from precisely the opposite cause—not the exhaustion of nervous activity, but its absolute non-existence.

We do know some conditions that seem to be conducive to

sleep. A mind at peace with self and the world, a healthy body, youth, full habit and lymphatic temperament are natural conditions in which sleep is normal. Like eating, drinking, and the performance of some other functions, "going to sleep" is to some extent voluntary. Therefore, we being willing, by cessation of labor and the removal of disturbing agencies, by assuming the horizontal position, and with the favoring help of darkness, Morpheus, under ordinary circumstances, readily accepts the invitation.

We are also passively susceptible to external influences that appear to bear a causative relation—apart from hypnotic influence that one person may be able to exert on another—as gentle massage, rocking, singing, or humming drowsily, the art of the gentle old nurse; and any monotonous sounds, like the rattle of wagons or cars, the roar of waterfalls or surging splash of the ocean surf, or even a soporific sermon. With the physiologically active agents that can produce sleep artificially—the long list of hypnotics and narcotics that is daily growing larger—must be classed extreme cold, excessive heat, and alcohol.

Thirdly, What causes prevent Sleep? This problem is not only subtle because difficult to answer; but also difficult to answer because so very prolific in possible remote causes. As we have seen we do not know with certainty the causes of sleep, how can we know the inherent causes that prevent sleep? *Vice versâ*, if we could know the immediate causes preventing sleep, why should we not know the causes of sleep? As we know some conducements, favoring and assisting causes, in fact many mechanical, chemical and dynamic remote causes of sleep, so we do know many remote causes of sleeplessness.

Sleeplessness is not always an indication of disease. It may be caused by external interrupting causes, as noises of various kinds; also by anything that would be at variance with the habit, or an abuse of health—as protracted overuse of the brain, over anxiety of mind, and unwise worrying regarding the past or future. In a general way, also, pains of all kinds; indeed, anything making unaccustomed impressions upon the nervous system. These are a few of the many causes of sleeplessness in health. As one would suppose, therefore, it is not a diseased condition. When associated with disease it is simply a concomitant, rather even a symptom, of disease.

We have said that possibly anæmia, and it might be that hyperæmia, is the cause of sleep. Well, possibly anæmia or hyperæmia is the cause of sleeplessness as well, and elaborate papers have been based upon this theory.

The remote causes of sleeplessness include the bilious and nervous temperaments, and an innumerable array of diseases, general as well as localized, of the body as well as the brain. Its presence or absence, its severity or persistence, is no guide to the diagnosis of the disturbance upon which it depends, for in such important lesions as organic diseases of the brain it may be absent, while it is a frequent and obstinate symptom in such prevalent affections as the functional derangements of digestion. Again, a disease may have it in a pronounced form in one patient, in a modified degree in a second, and not at all in a third; and in the same disease in the same patient it may be present at one time and not at another. Laurence Sterne made Tristram Shandy express a wish to "write a chapter on sleep; it is a fine subject," he says; and so it is a "fine subject," and for poetic effusiveness glorious, because the state is unhampered by an excess of knowledge regarding "The Mystery of Folded Sleep."

The *last proposition* suggested is regarding a removal of the causes preventing sleep. We do not know what sleep is, we do not know what causes sleep, and we do not know what causes prevent sleep. It is fair to question whether what we know about the cure of sleeplessness can be very trustworthy or worth recording. Fortunately, prescribing for a disease or symptom does not presuppose a comprehension of its inherent qualities any more than does the modification or the use of a natural law presuppose its comprehension. What we know about the inherent properties of electricity fortunately has nothing to do with our electric light, telephone or telegraph, and what we don't know about it has no bearing on the mathematically accurate facts in the thousands of volumes that bear on that subject. Consequently, MacFarlane's 300 octavo pages on the "Therapeutics of Insomnia" express only a minute portion of what we can and should know in this respect.

Sleep has been called the "chiefest thing in physic," and deserves more careful study than is possible within the scope of such a paper. Question—How shall the causes that prevent

Sleep be removed? The Irishman's answer "remove them" holds good to a great extent here: many of the remote causes can be removed by simply knowing them. They are very numerous, and we have tried only to classify them in our previous paragraph. Perfect living of our daily lives will frequently be all that is required to insure sweet sleep. To relieve the hyperæmia of the brain that causes sleeplessness, fill the stomach with solid food that is coarse and plain, so as to encourage the departure of the blood from the brain. For the excessive anæmia, and nerve irritability causing anæmia of the brain, give liquid food, as hot milk, beef-tea and broths about an hour before sleep is intended—to nourish the blood and increase its quality and quantity.

Another method to induce sleep is massage, properly done according to Dr. Weir Mitchell's instructions. The indications are, sedentary habits, imperfect circulation, digestion and assimilation. Warm baths, especially at night, fresh air, comfortable beds, sufficient and proper bedclothing (not too much), and proper position in bed, are among the simple means for inducing sleep.

The medicines for inducing sleep might be divided into classes as numerous as there are diseases in which it occurs, it being merely a concomitant and very erratic symptom. Like all other symptoms, it is most successfully dealt with from a therapeutic standpoint by prescribing for the "totality of symptoms," and not by giving the insomnia undue prominence. Sleeplessness is a common symptom, a large percentage of all diseases having it, more than a hundred remedies possessing it prominently. According to Hahnemann's rule that "uncommon and peculiar symptoms" be the guide to the remedy, this symptom can very rarely, therefore, be an important guide. It does become more important as we differentiate the peculiar forms and modalities of sleep—in other words, only in so far as sleep becomes a "peculiar" symptom in the case, and, on the other hand, as sleeplessness becomes a characteristic symptom in the pathogenesis of the remedy.

Arum, bell., cact., cham., coff., cyrip., nux v., op., stram., staph. and sul. have this symptom pre-eminently as a guiding symptom. Acon., agnus, arn., ast. r., benz. ac., bry., camph., canth., cina, cinch., clem., coca, coccion., coloc., cuprum, dig.,

dros., ferr. ph., gels., glon., graph., guaiac., hell., hyos., ign., iod., ipec., iris, kali bi., kali c., kreo., lach., lycop., magn. c., med., mez., natr. m., natr. s., nux m., phos., phos. ac., plumb., podo., rhus, sec., senecio, sep., stram., tarant., thuja and vinca minor—all do also lay claim to this symptom as a characteristic.

These remedies have also been classed variously according to the pathological significance of the sleeplessness, or according to the pathological condition the insomnia accompanies. As, for example, a class affecting the vaso-motor system, a class acting on the heart regulating circulation, a large class acting on the various organs of the body, and a class acting on the cerebro-spinal system. There are special classes of remedies suggested by special diseases, like *nux vom.*, *phos. (θ)*, *avena sativa* and *macroton* in the opium habit and drunkards. It is not within the scope of this paper to review and differentiate the characteristic symptoms and conditions of these many remedies, and those of a score or more prominent ones unnamed.

After following that will-o'-the-wisp labelled "specific," like the credulous Ponce de Leon in search of the fountain of youth, led by enthusiastic prescribers who would not dare to stand up here now and in their hypocrisy or ignorance say, "Of course not;" and—tell it quietly—induced by homœopathic advertisements in homœopathic journals, price-lists and catalogues, to buy *Passiflora θ* in bulk, "much cheaper by the pound;" after prescribing *coff.*, *ign.* and *bell.* like mad, I humbly acknowledge that, after having had this experience, I wish to be put on record that, after fifteen years of vacillation, I am able to comprehend this one fact fully, and may I be accused of the ignorance and hypocrisy referred to if I speak of specific homœopathic hypnotics. Change the condition of your patient from the abnormal to normal as far as possible by hygienic and dietetic means and select your remedy according to Hahnemann's instructions, and the best possible results will ensue.

Lastly, a word, and only one, regarding narcotics, hypnotics and overpowering drugs. The physician who will prescribe *sulphonal*, *trional*, *paraldehyde*, *hyoscine*, *chloralamid*, *bromides*, *chloral*, and especially *opium*, to a patient, without any consideration of the case more than that it is one of insomnia, is a poor physician, and certainly no homœopath. Use them as

sparingly as chloroform and ether—admit that you have tried honestly, faithfully and with good judgment, and that you are unable to do better in selecting the homœopathic remedy; don't be afraid to learn the dosage of hypnotics, as well as their objectionable effects, in detail—and we believe Hahnemann would agree that we were doing our best, and the best for sick and sleepless humanity, and that, like chloroform and ether, all of them should have their undisputed individual places of importance.

THE COLORLESS CHROMOGEN OF METHYLENE-BLUE IN URINE.

BY CLIFFORD MITCHELL, M.D.,^{*} CHICAGO.

THE dye known as methylene-blue, which commercially is said to be a zinc double chlorid of a sulfur base of dimethylanilin, is now used for diagnostic and therapeutic purposes in diseases of the urinary tract. When taken internally or by hypodermic injection the dye usually colors the urine a blue-green, and the time required for the disappearance of this color, when a dose of one grain has been given, is deemed significant of the ability or inability of the kidney to do its normal excretory work on time. That is, a prompt disappearance of the dye (within thirty-six hours) may probably be taken as an indication that the kidneys are normally ridding the blood of urea, salts, and other urinary constituents, even if the urine contain albumin and casts; while a delay in the disappearance of the color, when prolonged to four days or more and repeated, is to be taken as a sign of latent uræmia, even if definite uræmic symptoms are absent (Herter).

In some cases, however, the dye fails to color the urine at all, being excreted wholly in the form of a colorless chromogen; in other cases the color may disappear, but the excretion of colorless chromogen still continue. It becomes important, therefore, to detect the presence of this chromogen in the cases in which the blue-green color happens to be absent. According to Herter, if the chromogen is present, addition of dilute acetic acid to the urine will then color the latter green. The writer, however, has recently studied a case in which it was

necessary to boil the urine after addition of the acetic acid in order to bring out the color prominently, though a faint green coloration could be seen in the cold. In stale urine, boiling may be absolutely necessary to bring out the color after addition of acetic acid. The influence of this colorless chromogen on the various urinary tests has been investigated by the writer as of some importance to the general practitioner. When the urine itself shows the blue-green color, the physician will have little difficulty in determining the presence of the dye. When, however, the color is absent but the chromogen present, curious colors may be obtained in performing the usual tests which may puzzle the inexperienced, especially in the absence of information that methylene-blue is being taken.

The case which the writer has studied is one in which methylene-blue had been taken for therapeutic purposes in cystitis. The day urine of the patient was a faint blue-green, but the night urine a pale yellow with so faint a tinge of green as to escape anything but the closest scrutiny. On mixing the day urine with the night and letting stand in a tightly corked bottle the green color disappeared in a few days, but the chromogen continued to give the green color with acetic acid in the hot urine for a week or more.

The influence of this colorless chromogen on the various tests is shown by the following:

1. Heller's test (cold nitric acid) for albumin: blue-green ring at junction of urine and acid, gradually increasing in size on standing, the blue-green color spreading throughout the upper layer.

2. Nitrous acid by contact as in testing for bile: about the same as above, except that the blue-green color appeared more quickly at the top of the upper layer.

3. Ultzmann's test (heat and acetic acid): on boiling the upper part of the column of urine no change took place till addition of a few drops of dilute acetic acid, when a blue-green tint was observed, becoming much more intense on further boiling.

4. Addition of a few drops, 0.5 c.c. of dilute acetic acid to the cold urine, 5 c.c. in amount; faint blue-green in the fresh urine; no change at all in the stale urine a week old until after standing for half an hour or so, when a faint blue-green was perceptible.

5. Spiegler's test by contact for albumin: no color.
6. Millard's test by contact for albumin: blue-green.
7. Tanret's test by contact for albumin: blue-green at juncture.

As Tanret's and Millard's liquids both contain acetic acid, the coloration was doubtless due to this substance. When the urine was a week old the color could not be seen at first.

8. Almen-Nylander bismuth test for sugar: no reduction, no blackening even on standing over night.

9. Fehling's test for sugar: no change in the hot mixture, but on cooling a muddy green turbidity resulted, as in cases where a trace of some reducing substance is present. In this particular case some accidental impurity in the dye might have been responsible for the reduction.

10. Haines' test for sugar: no discoloration, no reduction even on cooling or after standing over night.

11. Silver nitrate: on addition of silver nitrate to 5 c.c. of the fresh urine the usual curdy-white precipitate was obtained, which almost immediately blackened at the bottom, and finally a dark-brown precipitate settled down with a light blue-green supernatant liquid. This same reduction was also noted in the urine when a week old.

12. Barium chlorid test for sulfates: the usual white precipitate, with a faint blue-green supernatant liquid.

13. Uranium acetate and nitrate, as in determining quantity of phosphates: brilliant blue-green with each, the urine being heated on the water-bath, as in the determination of P_2O_5 .

14. Indican test: on addition of equal parts hydrochloric acid to the urine a slight greenish tint was observed, which was almost but not quite overcome by the usual violet color on addition of hypochlorite.

15. Ferric chlorid test: on addition of 0.5 c.c. of a 20 per cent. solution of ferric chlorid, Fe_2Cl_6 , to 5 c.c. of the urine in the cold, the usual whitish precipitate was obtained, with an olive-green liquid at the bottom; when the precipitate settled, a green supernatant liquid was observed.

It will be seen from the above that the colorless chromogen of methylene-blue when present in urine complicates several of the ordinary routine tests, notably Fehling's test for sugar and the nitrous acid test by contact for bile. Use of Haines'

test-liquid, which is not affected by the chromogen, nor always by accidental impurities of the dye, will serve to distinguish the latter from traces of sugar, and absence of biliary features in the urine differentiate the chromogen from bile. Moreover, the blue-green color which the chromogen yields with nitrous acid is lighter and brighter than the dull grass-green of bile; and the absence of other colors, together with the spreading of the blue-green throughout the upper layer, indicates the presence of the chromogen, when at the same time the urine boiled with acetic acid shows the blue-green tint which biliary urine similarly treated does not show.

The blackening of the silver chlorid precipitate on addition of silver nitrate to the urine is gradual, and should not interfere with observation of the presence of chlorids, while the brilliant blue-green color obtained in the quantitative determination of phosphoric acid does not appear to affect the end reaction with potassium ferrocyanid.

In diabetic cases, where the ferric chlorid test for diacetic acid is made, presence of the chromogen may render the detection of diacetic acid difficult or impossible. In cases, therefore, of diabetic cystitis, the patient, if taking methylene-blue, should be directed to cease taking this substance until the test for diacetic acid has been made.

NASAL POLYPUS (MYXOMA).

BY I. G. SHALLCROSS, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Phila., Sept., 1899.)

THE myxoma is by far the most common variety of benign neoplasm found in the nasal cavities. Our knowledge of the process that precedes polypus formation is very vague. Bosworth says, "It is difficult to assign any definite cause for the occurrence of mucous polypi." They start as sessile tumors, and generally from the middle turbinated bodies, the mucous membrane of which is soft and delicate, and actively concerned in the respiratory function of the nose, viz., serous exosmosis. Consequently the conclusions of the above-mentioned authority

that "as a result of this serous transudation the membrane becomes saturated or water-soaked, as it were, in such a manner as to lead to the development of this peculiar myxomatous condition." The polyp, being developed as a sessile tumor, is then subject to the action of gravitation, which, together with the traction produced by blowing the nose and the to-and-fro motion of breathing, causes it to gradually sag down and become filled with serum. It now drags on its attachment above, and a pedunculated tumor is in this manner formed.

Woakes asserts the invariable association of nasal polypi with necrosing ethmoiditis; but here differing with this author, I must agree with Ivins, who says, "I must confess to very rarely finding this relationship, but believe such ethmoidal changes the result, not the cause, of the neoplasm."

Mucous polypi are more frequently found in males than in females. They are very rare in early child-life, seldom making their appearance before adolescence. They are probably most common between the ages of twenty and thirty years. Lennox Browne is of the opinion that they may occur during any period of life. I have seen the mucous polyp in a patient nearly eighty years old, and removed one from a boy of nine years. Heredity has been cited as a cause of these growths, but I am inclined to believe, where two or more cases occur in the same family, that the fact is a mere coincidence.

The external surface of a polyp is covered with the epithelial layer lining the mucous membrane of the nasal passage, the epithelium being frequently of the ciliated variety. Immediately under this is a layer of fibrous tissue which contains the tumor proper, a true hypertrophy of the structures of the mucous membrane, namely, fibres of connective tissue, a large amount of mucous- and fat-cells, glandular tissue and blood-vessels. In shape they resemble a pear, and vary in size from a mere pin-point to the entire capacity of the nasal cavity. In color they are a pinkish or bluish-pearl. They are generally attached to the middle turbinated bone or its adjacent tissue. I have removed true mucous polypi from nearly every portion of the nasal chamber, including the septum and inferior turbinated, although in the former position the tumor is most likely to be an angio myxoma, and in the latter it usually presents itself as a polypoid degeneration.

The first symptoms of nasal polypi are sneezing and a profuse watery discharge; the latter from the mucous membrane, not the polyp. As the growth develops in size, nasal stenosis appears; most marked at first in the upper part of the passage, causing a sense of fullness and distention, which is often more distressing in the nervous irritability which it causes than if the obstruction were in the lower respiratory region, which region becomes totally closed in many cases as the growths enlarge. They usually start in one fossa, but almost invariably develop in the other in a short time. The stenosis varies notably under atmospheric conditions; thus we find it of greater degree during damp or rainy weather. This is undoubtedly due to the hygroscopic character of the growth, although Bosworth claims it is due to the mucous membrane entirely. The voice is markedly nasal, or, more properly speaking, is devoid of nasal resonance; and an experienced rhinologist will often suspect the nature of the case from this characteristic voice. In severe cases the nasal bones are often displaced, due to the lateral pressure exerted by the growths, giving the characteristic appearance euphoniously designated frog-face. Polypoid growths very frequently give rise to epiphora by obstruction of the mouth of the nasal duct, and they occasionally seem to cause disease of the antrum of Highmore by occlusion of its orifice or invasion of its cavity. I have also seen empyema of the frontal sinus, due to obstruction by a polyp. In addition to the above symptoms of nasal polypi, there is a characteristic profuse discharge of thick mucus having a musty, pungent odor. Anosmia is an almost constant accompaniment of the condition, but is most marked where pressure is exerted in the olfactory region. The sense of taste is also at times seriously impaired. The aural symptoms are directly due to stenosis and interference with the normal respiration, and consist mainly in the development of chronic catarrhal otitis media. The patient being of necessity a mouth-breather, irritability of the pharynx and larynx is to be expected, and is usually pronounced. Reflex headache, cough or asthma are frequently relieved by the removal of a polyp situated high up in the nasal fossa.

The diagnosis of nasal polypi is, as a rule, easy; a grayish-blue or pink tumor, freely movable when large; easily indented

with the probe, the indentation disappearing quickly on the removal of the probe; and the general health of the patient, as a rule, perfect.

When the tumor is small, or situated far back or high in the nose, cocaine or a fresh solution of the desiccated suprarenals should be used; the collapse of the erectile tissue of the inferior turbinated greatly facilitating the examination. Frequently, small polypi are situated in the middle meatus, the middle turbinated hiding the tumor. In these cases the polyp can frequently be thrown out of its bed and brought into view by employing a bent probe in the middle meatus.

Frequently polypi are attached so far back on the middle turbinated as to require a posterior rhinoscopic examination to detect them; and occasionally they hang well down in the naso-pharyngeal region.

When a true hypertrophy of the turbinated exists, diagnosis of small growths may be rendered quite difficult; the tissue not responding to the action of cocaine or the desiccated suprarenals, as it does in the case of a simple turgescence or pseudo-hypertrophy.

Papilloma on the inferior turbinated is easily distinguished from a polyp by its red color, and presents no difficulty in diagnosis. Angiomata are found more frequently on the septum; they have a broad base, are of a deep-blue or purplish-red color, and bleed easily. Fibromata are hard and offer resistance to the probe, and in color they are white, although they are more highly vascular than the simple myxomata. The cystic polyp is more translucent and has more the appearance of a bag of water.

The prognosis is distinctly favorable, although anosmia and frog-face are at times permanent. There is a decided tendency to recurrence of the growth, either at the same attachment or in adjacent structure. Examples of degeneration of polypi into sarcomata or carcinomata are reported. Most of these cases follow clumsy operating. I am of the opinion that had many, if not all, of these cases been examined microscopically, the cancer-cell would have been found in the earliest manifestation of the disease.

Although remedies have their place in the treatment of nasal polypi, I doubt if they alone ever cure a case of this disease.

I have tried them and have unquestionably held cases in check, but have never seen a cure from purely medicinal treatment. *Calc. Carb.* has been my best remedy when persistently used. *Sang. canad.* should be used after operating, as it seems to prevent recurrence. *Hydrastis* is often a good remedy when used for the catarrhal symptoms. *Calc. phosph.*, *kali nit.*, *thuja*, *conium*, *ferrum phosph.*, *kali bichrom.*, *sulphur* and *teucrium* have all been used in these cases. The use of acids injected into the tumors I must condemn, as they leave a sloughing mass in the nostril for many days and may be the cause of septic poisoning. Electrolysis has been advocated but is not generally employed by rhinologists, as the results are slow and uncertain. The old-fashioned method of removing polypi by means of the polyp forceps and without proper view of the seat of operation is now almost obsolete. There can, however, be no rational objection to the use of the alligator-jaw, angular forceps, when the part is well illuminated and the attachment of the growth can be easily grasped. Most surgeons prefer to use the cold wire snare; the instruments devised by Jarvis, Bosworth and Sajous are now in general use. For my own use I prefer the Bosworth or Weaver modification of Sajou's snare. Before any operation in the nasal fossa the parts should be thoroughly cleansed with an antiseptic alkaline solution, after which we may make two or three applications of a fresh solution of the desiccated suprarenals (10 to 15 grains to 5j) to the turbinates and seat of operation; the action of this drug giving us practically a bloodless operation and allowing more room for the employment of instruments. As it does not control pain, we must follow its use by one or two applications of a 4 per cent. solution of cocaine before commencing the operation. The medium-size piano-wire should be used in the snare. As large a loop as possible is introduced along the septum vertically so that the wire passes the tumor; it is then turned horizontally and made to encircle the tumor, and as it is pressed up toward the point of attachment the wire may be slightly tightened until it is made to grasp the pedicle at its attachment. The wire may now be tightened around the pedicle, and with a twisting motion of the hand the mass pulled off, or by drawing the wire home it may be made to cut through the pedicle at its base. By the former method we have more bleeding and more

pain, but are less likely to leave a stump of the polyp remaining in the nose than by the latter procedure. We should remove as many tumors as possible from one fossa at the first sitting, and repeat the operation every week or ten days until both nares are completely clear. Bleeding may be quite profuse after operating but it is easily controlled, and in my experience has never been alarming. We are advised to always cauterize the point of former attachment after the removal, so as to prevent recurrence. In my experience the growths have returned even after a careful attempt has been made to cauterize all raw surfaces. On the day of operation it is almost impossible to carefully cauterize because of the hæmorrhage, and I quite agree with Bosworth that later it is impossible to find the point of attachment if the polyp has been properly cut off close at its base.

The galvano-cautery snare is more painful than the cold wire and is placed in position with much greater difficulty, owing to the flexible nature of the platinum wire. The use of powdered sanguinaria root as a snuff has been advocated by some, to prevent recurrence. My own opinion is, that the best preventive measure is careful attention to the condition of the nasal mucous membrane, with the correction of any deformity that may exist within the nasal cavities.

After the complete removal of all nasal polypi the case should be carefully watched and examined every few months for possible recurrences. Should these occur, they should speedily be removed, and careful watch of the nasal fossæ kept up until we are assured of the cure of the condition.

CONTUSIONS OF THE ABDOMEN—WITH REPORT OF TWO CASES.

BY HERBERT P. LEOPOLD, A.B., M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, October 2, 1899.)

THIS condition is the result of a blow with a hard, blunt object, or of violent compression, and may result in injury to the abdominal wall alone, in injury to the abdominal viscera alone, or in injury to both wall and viscera. The gravest abdominal injuries sometimes exist without the slightest external evidence of injury, with possibly slight pain locally at the point of impact.

The abdominal wall may be but slightly injured, and there may yet exist a considerable extravasation of blood, or extensive laceration of the muscles and other tissue. A very slight external injury to the abdominal wall may be associated with a severe injury to the viscera. The external appearance cannot then be taken too seriously, and further investigation becomes imperative.

Symptoms.—Excruciating pain, nausea and vomiting, distention, restlessness, small irregular pulse, rigidity of the muscles and pallor are the prominent ones, and are arranged in the order of most frequent occurrence. These symptoms are mainly due to the concussion of the widely distributed sympathetic system. This may be exemplified by calling to mind the extreme prostration resulting from a blow inflicted over the solar plexus in a recent pugilistic encounter. Even sudden death has followed a violent blow over this region.

Diagnosis.—First, Nature of the applied force; Second, The direction of this force; and, Third, The symptoms presented. These must *all* be considered before arriving at a diagnosis. First, The Nature of the applied force. That is, the size and shape of the instrument causing the injury, and the relative amount of force applied to produce the impact with the abdominal wall. Second, The direction of this force. This plays a very prominent part in the diagnosis, since a horizontal impact is attended by graver consequence than an oblique one of equal force. Third, Symptoms presented, which have already been alluded to. The lesions of the stomach and intestines are usually caused by squeezing between the compressed abdominal wall and the vertebræ. A theory advanced by some writers is that the gut is partially distended with a liquid or semi-liquid, and by the pressure they are burst through over-distention. The positive early signs of intestinal perforation are the distinctness of the heart-sounds over the abdomen, due to the escape of intestinal gases into the peritoneal cavity, and the acceleration and subsequent slacking of the pulse, due to the absorption of these gases, acting as a cardiac poison. These, together with persistent vomiting, tympanites, and, later, the symptoms of peritonitis, are indicative. The unoperative mortality of these cases is 96 per centum. Violent hæmatemesis is indicative of a marked lesion in the stomach. Should a rupture of this

organ be suspected, it may be dilated with hydrogen gas through a stomach tube. If the stomach cannot be distended, complete rupture has taken place, and the gas will distend the abdominal cavity.

If there is a rupture of the capsule and parenchyma of the liver, it may be recognized by the peculiar radiating pains, severe state of shock, and the rapid exsanguination. In an injury to one or both kidneys, hæmaturia is the important indication, but this may be delayed a few hours. Enlargement of the lumbar regions is present in severe cases. Anuria may occur, but as a symptom it may only be used to substantiate. Immediate recognition when possible, and then proper surgical intervention, are the only chances that can be offered. Laparotomy, to prove successful, must be early—not later than 24 hours after the injury.

CASE I.—John MacK., 28 years of age, Ireland, longshoreman, gives the following history. “While walking behind a heavy dray horse I was kicked in the abdomen.” He came directly to the hospital, and for some reason was not seen until the next morning at 9 o’clock, when he presented the following symptoms: An ecchymosed area over the stomach and liver, pinched expression, pallor, and complained of agonizing abdominal pain, tenderness over the site of injury, tympanites, nausea, and vomiting of bright red blood, pulse thready and weak, temperature about 101° F. He consented to immediate exploratory laparotomy. An incision from Xiphoid cartilage to umbilicus was made. On opening the peritoneal cavity bright blood with clots, serous fluid and the contents of the stomach effused. On a closer examination the stomach was shown to be ruptured at the pyloric end, and a slight laceration of the capsule of the liver. The cavity was washed out with a normal saline solution and the wound in the liver packed with iodoform gauze. The lacerated edges of the stomach were trimmed, and the mucous membrane was united by a continuous row of catgut sutures and the muscular and serous coats by a continuous row of Lembert sutures of fine white silk. The abdominal cavity was again washed out and the incision partly closed. One end of the gauze drain was left out at the lower angle of the abdominal incision; this was removed at the end of 48 hours and the incision completely closed. An uneventful recovery. The patient left the hospital at the end of three weeks.

CASE II.—John M., aged 10 years,* German, while playing

in the street was run over by a light delivery-wagon, the rear wheel passing over the abdomen about the level of the umbilicus. He was sent to the hospital about one hour later in a state of severe shock. Temperature 97° F., shallow breathing. Patient was put to bed and hot-water bottles placed around him. Head was kept low, oxygen given at frequent intervals, hot rectal injections of a normal saline solution. He rallied in about two hours, and it was decided that his condition was due to a direct disturbance of the sympathetic system with a possible escape of gastric or intestinal fluids into the abdominal cavity.

The symptoms as presented were a rapid and weak pulse, vomiting, tenderness and rigidity of the abdominal muscles, with some tympanites. Consent was given for an operation. On opening the abdominal cavity the intestines were found to be slightly congested, and covered in areas with fibrin exudate with an excess of fluid in the cavity. The small intestines were drawn out and a linear rupture two and a half inches long was found; this was closed with a Lembert suture. Further search failing to reveal any other lesion, the gut was replaced and the cavity flushed out with about a gallon of hot saline solution. The intestines were wiped off and about a pint of this same solution introduced, and the cavity closed. With the exception of a few days of restlessness, pain and temperature, the boy made a speedy recovery, and was discharged in sixteen days.

PNEUMONIA, CHRONIC BRIGHT'S DISEASE, RHEUMATOID ARTHRITIS.

BY WALTER SANDS MILLS, M.D., NEW YORK CITY.

(A Clinical Lecture Delivered at the Metropolitan Hospital, February 14, 1900.)

Pneumonia.—This man is 26 years of age. He entered the hospital last October with some rectal trouble and was subsequently operated on. February 11th, Sunday, he says he felt that he was exposed to a draught. A little later he had a severe chill and his temperature ran up to 104° F. He also complained of much pain in one side. When I saw him yesterday, the 13th, there were several noticeable objective symptoms, namely, a flushed face, rapid breathing, rapid pulse. I will consider them in detail. A flushed face may be transitory, as from blushing. When due to blushing the flush comes suddenly, and then more or less rapidly disappears. A flushed face may be a chronic condition, due either to exposure

or out-door life, or to some lesion of the skin. A flushed face may be due to some profound disturbance, like cerebral hæmorrhage. This latter condition would cause a stupid expression of countenance as well as the flush, and the patient would probably be unconscious. In the patient before us, however, we have simply a light flush. This is an objective symptom that goes with acute fevers. The flush is not transitory, as in blushing; it has not the healthy appearance of one leading an out-door life; it has not the stupid expression that goes with cerebral hæmorrhage.

The next objective symptom to which I wish to call attention is the rapid breathing. Respiration is accelerated to some extent in all acute infectious diseases. When I saw this man yesterday he was breathing 40 times a minute. Just now his respiration is 32 a minute. Rapid breathing without previous exertion means trouble in the respiratory organs. We sometimes find it in pneumonia, in pleurisy, in consumption, and in some other conditions. To know why the breathing is rapid we must have the associated symptoms. Rapid breathing, of itself, merely points to the organs of respiration. In the patient before us we see that the breathing is rapid. It is 32 a minute; it should be 16 to 18. There is some pain in the lower right side of the chest. As stated before, the pulse is rapid. I find it full and beating 90 times a minute. Please note the ratio between the respiration and the pulse. Respiration 32 a minute, pulse 90 a minute; a ratio approximating 1 to 3. The normal ratio is about 1 to $4\frac{1}{2}$. What does this change in ratio mean? It points very strongly towards pneumonia. This great change in ratio of respiration to pulse is almost pathognomonic. In other conditions with rapid breathing the pulse is apt to increase so as to maintain the normal ratio of 1 to 4 or $4\frac{1}{2}$. In cases of rapid pulse without rapid respiration the ratio increases, instead of diminishes, as in pneumonia.

Before proceeding to make a physical examination I get a record of the temperature. We have a history of chill, followed by a sudden rise in temperature two days ago. With slight variations this temperature has remained high ever since. The temperature-curves of the various fevers differ very much. In pneumonia the initial rise is abrupt, the daily variations are

very slight, the crisis is abrupt. Crisis occurs most often on the seventh or fifth day. There is no other disease that presents exactly the same curve. Typhoid fever, as you know, has gradually increasing temperature each day for a week or ten days, then a constantly high temperature with considerable daily variations for another period of a week or more, and then the gradual fall by lysis. In the eruptive fevers we have the rash to aid us as well as the temperature chart. In measles the initial rise is abrupt, but we have a slight remission in a day or two, followed by another upward movement beyond the point of the initial rise. In intermittent fever we have a sudden rise, followed by a sudden fall, the cycle being completed in a few hours. And so I might go on with each disease entity.

To return to the case before us, we have a patient presenting three objective symptoms indicating fever, respiratory trouble, and probably pneumonia. Physical examination reveals the slight dullness and the subcrepitant *râles* of pneumonia. These signs are found only at the lowest part of the right side of the chest at the side and back. The disease is therefore in the lowest lobe of the right lung.

I have had the patient dressed with a woolen undershirt. I believe this to be all the protection necessary. The so-called pneumonia jackets I am opposed to. They overheat the patient and make it dangerous to remove for examination of the chest. I have seen at least two patients die from sudden chilling of the surface of the body in changing jackets. The woolen shirt is just as useful, and examinations can be made, when necessary, without removing it.

My first prescription for this case was *ferrum phosphoricum* 6x, a tablet every hour. The patient was feverish, at the same time he complained of chilliness of legs especially. His face was flushed, his pulse full. He was not restless enough for aconite, the congestion was less than in belladonna. To-day the temperature has gone down some. Perhaps it is a pseudo-crisis and will be higher to-morrow. I have seen two cases of pneumonia aborted by the use of *ferrum phosphoricum*. It will not abort this case; the disease is too far advanced. I believe it to be the best remedy now. Later I shall probably follow it with bryonia.

Chronic Bright's Disease.—This patient has been sick for

nearly two years. The last two or three months he has gotten much worse. The leading symptom in his case is œdema. He has fluid in the abdominal cavity in large quantity, and a general œdematous condition throughout the body. The pulse is weak and about 80. He also has some cough. The urine has been scanty, high-colored, of normal specific gravity, and with diminished urea. It contains albumin, fatty and hyaline casts. The trio of symptoms indicating Bright's disease are dropsy, albumin in the urine, uremia. In many cases all three symptoms appear, in some only two of them. They occur in all forms of Bright's disease, acute and chronic, so that it is sometimes impossible to tell whether you have an acute or a chronic condition to deal with. I have seen a number of cases presenting every symptom of acute Bright's, cases with no obtainable history of previous trouble, where the necropsy revealed chronic conditions that must have been of long standing.

This patient, however, has been in hospital long enough for us to say definitely that his is a chronic case. The pathologists have given us many subdivisions of the various forms of kidney inflammation, but it is not always possible to make such numerous clinical differentiations. It must not be forgotten that in all cases of chronic Bright's disease all portions of the kidney are affected. The two most common divisions are chronic parenchymatous and chronic interstitial nephritis. In the first the trouble is greater in the secreting portion of the kidney. In the second the principal trouble is in the interstitial portion. This patient has well-marked œdema, or anasarca, rather—it is general. This is a more marked symptom in the parenchymatous form of the disease. The specific gravity of the urine is about normal. In the interstitial form of the disease the specific gravity is low. There is a large quantity of albumin. This is also characteristic of the parenchymatous form of the disease. The secretion of urine is scant. Again, we have a symptom of the parenchymatous form of nephritis. The diagnosis, therefore, is chronic parenchymatous nephritis. He has had various remedies. At present he is on *arsenicum album* 3x. I prescribed arsenic on the general condition and on the peculiar waxy pallor of the skin. He has had it for several days. Before he got arsenic he was passing six, eight and ten ounces of urine in the twenty-four hours. Since getting arsenic the quantity of urine has more than doubled.

Rheumatoid Arthritis.—You will notice in this case the peculiar distortion of the joints of the fingers. This patient has been in hospital for two months, all of that time in bed. He is suffering from a disease the pathology of which is little understood. It is found more often in women than in men, and usually does not make its appearance until the age of thirty-five or forty. It is essentially chronic in its nature. Occasional cases have been cured. Some have had the disease process stopped. The majority appear to be little influenced by medicines. This man has had a good many drugs. Before I came on duty he was on iodide of potash for several weeks, but without result. A few days ago he developed acute symptoms—pains, heat, and so on. He was placed on *belladonna*, and now is much relieved. On the whole, he is at present doing as well as we can expect.

ASCITES.

BY R. G. HIGGINS, M.D., PRINCETON, IND.

By ascites is meant an accumulation of serous fluid in the peritoneal cavity. It varies in amount, in different cases, from several ounces to several gallons. It almost always follows some organic disease of near-by organs *e.g.*, heart, lungs, liver and kidneys; hence it is not a disease *per se*, but a symptom of many diseases. Roberts arranges the causes as follows:

I. Pressure, interfering with free portal circulation, giving rise to a transudation of the fluid portion of the blood into the general peritoneal cavity. The pressure may be extra or intra-hepatic. Under these circumstances there is no general dropsy, but simply the peritoneal effusion (ascites).

The pressure may be due to malignant diseases of the liver, *e.g.*, cancer, cirrhosis, or syphilitic induration; to enlarged absorbent glands in the vicinity, a neighboring tumor (cancer of the pancreas or lesser omentum), and hepatic aneurism.

The extent of the obstruction will vary with the extent and position of the hepatic involvement or the involvement of neighboring structures. Not only the portal vein, but also the hepatic vein and vena cava, may be affected by pressure from the above causes.

II. Cardiac or pulmonary diseases, where the venous circulation is involved, give rise to ascites, owing to the backing-up of blood on the liver. Congestion, and even hepatitis, may result, and finally hepatic circulation will become obliterated. Ascites, under these circumstances, follows œdema of the lower limbs.

III. Ascites may result from nephritis. It is then a part of a general dropsy, and appears subsequent to an œdema of the extremities and face.

IV. Morbid conditions of the peritoneum occasion ascites. Peritonitis, cancer or tubercle—even an abdominal tumor, which causes no obstruction to portal circulation—may result in ascites from peritoneal irritation.

V. Miscellaneous—Exposure, cold and wet, sudden suppression of habitual discharges, extreme anæmia, and debility. These causes are supposed to originate active internal congestion or disturb renal function, but it is highly improbable that they alone can occasion ascites.

Anatomical Characteristics.—The fluid is generally of a watery consistency and amber-colored, with an alkaline reaction—rarely neutral or acid. It may be tinged with blood or bile; if so, it is thoroughly mixed, and does not precipitate on standing. At times the fluid is turbid, dirty-looking or milky.

Chemically it is water holding albumin and salts in solution. In renal dropsy urea may be present.

Symptoms: Usually the fluid accumulates gradually. It may form rapidly. The abdomen presents a general enlargement proportionate to the amount of fluid. Often this is the first symptom noted by the patient. The enlargement begins in the hypogastrium, gradually creeping up as the fluid increases. The extent of enlargement depends upon the amount of fluid. If large, the abdominal walls are put upon a stretch, the umbilicus obliterated or everted, and the skin presents a shiny, smooth appearance. The fluid gravitates to the most dependent portion of the cavity, unless, under exceptional circumstances, it is walled off by adhesions. A change in the position of patient is followed by a shifting of the fluid.

Physical Signs.—Dullness over seat of fluid, abdominal resonance on upper side of effusion, and fluctuation, together with the above objective symptoms. Auscultation reveals nothing.

The seat of dullness or resonance depends upon the position of patient. If in decubitus, resonance is above, dullness on the sides; if, sitting or standing, dullness in hypogastrium, resonance in epigastrium, etc. When in doubt as to diagnosis, aspiration may be resorted to.

It is unnecessary to give the differential diagnosis of the various pathological conditions which it is necessary to exclude in forming an opinion. I will mention one of importance (œdema of abdominal walls) which I have met, and am unable to find in works at my disposal. It follows œdema of lower limbs, and objectively has the appearance of ascites. The physical signs present are pitting on pressure, presence of umbilical wall, absence of fluctuation, and flatness. Percussion-note may be slightly dull, but area of dullness does not change with position of patient. Pricking the abdomen with a needle will be followed by escape of serous fluid. This condition may be present in general dropsy and there be no ascitical accumulation. Prognosis depends upon the cause. Idiopathic cases are favorable. If from organic changes in heart, lungs, liver, kidneys, or adjacent organs, unfavorable.

Treatment.—If possible, find the cause and remove it. It is not the purpose of this paper to go into the treatment of all diseases accompanied by ascites. If, in spite of the administration of remedies suitable to the cause, the fluid continues to increase, palliative measures may be applied. These consist of cathartics, pseudorifics and diuretics. Eventually the accumulation may be so great as to cause respiratory and cardiac embarrassment. Then abdominal paracentesis should be done. It may be repeated as often as the condition demands. Within the past year we treated a case supposed to have cirrhosis of the liver. Since September 2, 1897, he has been tapped about eighty-five times; for awhile it was done every three days. There has been no accumulation since February 28, 1899. Patient is now in fair health, and able to work. Tappings became less frequent after the administration of *apis mel*. I think the remedy may safely be given the credit, although Roberts says ascites from cirrhosis has been cured by repeated tappings.

ENURESIS.

BY CALDWELL MORRISON, M.D., SUMMIT, N. J.

THE subject to which your attention is called in the following paper is neither new nor startling. On the contrary, it is probably as old as the healing art, perhaps as old as the human race. No records have come down to us from those distant ages of fig-leaf garments and free outdoor life; but perhaps even in those remote times some children spoiled their nether garments by an involuntary passage of urine. Even so the accident must have been less annoying than in these modern days of more cumbrous clothing. But while neither novel nor startling, the disease—if disease it may be called—is important because of its frequency and often intractableness. Indeed, I think we sometimes, in our search for something new and striking, overlook the really more important, because more common, complaints that every physician is called upon to treat. Not many of us are called upon to perform hysterectomies or remove appendices; but to treat commonplace things like diarrhœa, or even the troublesome complaint of “wetting the bed” is a daily occurrence. And yet on just such things for most of us hinges our success or failure. So I ask you to consider the subject of enuresis to-day.

Etiology.—The causes of this bothersome malady, as usually given, are many. For simplicity's sake we will divide them into (1) general, or constitutional; (2) local, or reflex.

Among the *general* causes may be mentioned lithæmia, eczema, scrofula, diabetes, epilepsy, and, in general, constitutionally nervous temperament. It is true that enuresis occurs among the rich and the poor, the robust and the frail; but there is generally some constitutional dyscrasia back of the weakness. Children of nervous temperament are much more apt to be affected than those of sluggish disposition. On the other hand, the scrofulous, the rachitic, the poorly nourished are very likely to be afflicted. Improper food is another great cause of the trouble, children who are allowed to indulge in rich, highly spiced foods, and who take sugar and sweets to

excess, are more liable to suffer than those whose diet is simpler and more wholesome. The same is true of tea and coffee and pastry, which should be denied to children liable to suffer from this weakness.

Among local and reflex causes the most common is, among boys, an adherent prepuce; and among girls, its analogue, hooded clitoris. Rectal irritation from *worms*, pruritis, or other local cause, is another prolific source of the trouble. Excessive acidity of the urine, due perhaps to a lithæmic heredity, is another common cause, and naturally cystitis has a direct influence upon it. Under one or another of these heads, perhaps in a combination of several of these causes, may be found the source of this aggravating complaint.

Symptomatology.—Hardly anything need be said about the symptoms, they being so familiar to all. In fact there is only *one* symptom—the involuntary passage of urine. As a rule the involuntary micturition occurs at night, during sleep, but it *may* occur as a more or less constant dribble, even during waking hours. If the accident happens during the day, the child, if over four years old, generally has some premonition of what is going to occur, but seems unable to avoid it. After more or less nervous excitement, perhaps a clutching of the genitals, the sphincter suddenly relaxes and the clothing is saturated.

Treatment.—Coming now to the more important matter of treatment, the prime therapeutic law needs special emphasis, as usual. “*Tolle causam*”—remove the cause—this first of all, or you need not expect a cure. Easier said than done, but none the less necessary. It is often difficult to find out just what is the cause; and often still more difficult, having found it, to remove it. Still, patience, careful study and close observation will generally discover both the cause and a way for its removal.

The causes of enuresis being so manifold, naturally the treatment must vary accordingly. If the trouble is due to constitutional weakness or dyscrasia, that must be treated in order to cure the enuresis. *E.g.*, if the child is naturally lithæmic and rheumatic, with excessively acid urine, constitutional treatment directed to the relief of that condition is necessary. If diabetes is responsible for the enuresis, treat the former and let the lat-

ter take care of itself. If the child is anæmic, flabby and poorly nourished, good food, proper hygiene, plenty of fresh air, and perhaps tonics like iron, or even strychnine, are all-important.

Regulation of the diet is a most important feature in the treatment of most cases, even though the cause may not be referred to dietary indiscretions. Improper diet will certainly aggravate the trouble, from whatever cause it arise, and is often its sole cause. Most children who suffer from enuresis eat too much candy and sweets and spiced food. Often a complete cure will result from proper regulation of the diet alone. Enuretic children should be forbidden much sugar, highly-seasoned foods, spices, and sweetmeats; also, the fruits that are rich in sugar, on the one hand, or acids on the other. The evening meal, especially, should be both light and wholesome. Heavy meals at night, especially if they include meats and pastry, are a potent cause of enuresis. Many failures to cure this bothersome complaint are due to neglect in regulating the diet.

If local causes are operative in the production of the disorder, of course they are to be discovered and removed. Adherent prepuce or phimosis being a very common cause in boys, breaking up the adhesions and the retraction of the foreskin, or, where this is not sufficient, circumcision, is the evident cure of the complaint. A hooded clitoris in girls needs similar attention, the breaking up of the adhesions being often all that is necessary to effect a cure. Rectal irritation from pin-worms being often responsible for the trouble, a few doses of *santonin*, or an injection of quassia water, will probably work wonders. Pruritus of the anus or vagina needs local attention, if it exists, before you can expect to cure the enuresis.

Among general measures to be adopted may be mentioned the elevation of the foot of the bed several inches. This is often quite effective in those cases that occur in the early morning hours, or soon before the child arises. In these cases the enuresis is often due to the large accumulation of urine in the bladder during sleep, which by a purely reflex action opens the sphincter to relieve the pressure. By elevating the foot of the bed, and so taking the pressure off the sphincter muscle, the accident may often be prevented. This expedient is of little or no value if the enuresis occur soon after retiring. It may be

wise to waken children who suffer from early morning enuresis, and have them empty the bladder once during the night. It is important that children be not too warmly covered up at night.

Drugs.—The list of drugs applicable to this condition is quite large. Here, again, careful study and investigation of the cause is necessary in order to the selection of the proper remedy. Speaking in quite general terms, the writer has found the best results from *bell.*, *caust.*, *puls.*, *sulph.*, *sepia* and *rhus arom.*

Grouping our remedies according to the type and cause of the enuresis, we may mention *bell.*, *hyos.*, *gels.*, *ignat.* and *cham.* as especially useful in children of very nervous temperament. For enuresis due to constitutional weakness, such remedies as *ferrum*, *ferr. phos.*, *calc.*, *ars.*, *strych.* and *sulph.* come into play. *Sulph.* especially is valuable as an intercurrent remedy in almost any type of enuresis. *Cina* and *santonin* are called for in enuresis due to pin-worms or other rectal irritation. The lithæmic type of the trouble is best met by *berb.*, *benz. ac.*, *lith.* and *colch.*, while the frequent cystitis accompanying it is helped by *benz. ac.*, *borac. ac.*, *vesicaria*, sandalwood oil. "Sanmetto" is said to be an excellent preparation for enuresis, especially if associated with bladder or kidney trouble. I have had little or no experience with it, however. If the enuresis seems due to a catarrhal condition, *puls.* and *caust.* will be found especially useful, their well-known symptoms being present. *Caust.*, especially if the accident happen in the early part of the night. (*Sepia.*) Clinically, without any special indications calling for their use, *equisetum*, *rhus. arom.*, mullein oil, and *kali brom.* (1x trit. 1 gr.-doses) have been found useful. While attending lectures at the N. Y. Post-Grad. Med. School, I remember *rhus. arom.* was lauded by one of the professors in children's diseases as a recent "discovery," valuable in enuresis. Confidentially he told some of us, after the clinic, that he had found a "sure cure" for this complaint, and gave us his formula, which is as follows:

R. Fl. ext. <i>rhus. arom.</i>,	. . . . .	3 iv.
Elix. <i>aromat.</i>,	. . . . .	3 vj.
Aq. <i>cinnamomi</i>,	. . . . .	3 ij.
℞. Sig. 3j. t. i. d.		

Doubtless, the *rhus. arom.* is responsible for whatever virtue

the mixture possesses. I have tried this formula, and found it no better than plain rhus. aromat.

Equisetum is another remedy said to be valuable in enuresis, but I have had little experience or success with it. A writer in pediatrics relates the following rather funny experience. A child under his care, who had suffered some time from enuresis, and had resisted every treatment that had been tried on him, including circumcision and the general measures we have indicated, besides various drugs, was given by mistake some nerve tonic pills meant for his mother, with the result that in two days his enuresis was entirely cured, and did not return. The pills were composed of fl. ext. cannab. ind. (gr. $\frac{1}{8}$), hyosciamin (gr. $\frac{1}{400}$) and zinc phosphide (gr. $\frac{1}{10}$). Doubtless, in this case the child was one of excessively nervous temperament.

No attempt has been made to present anything startling or novel, the purpose of the paper being to provoke discussion, and draw personal experience with this, one of the most common, and at the same time most annoying and intractable complaints to which children are subject.

THE ARTIFICIAL FEEDING OF INFANTS.

BY JOHN L. REDMAN, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, September 5, 1899.)

MANY children are born with mothers not able to nurse them, either from a puerpera, mastitis, or interdicted by the physician because of tuberculosis, syphilis, or because the quantity of milk is not sufficient or the quality is not good. Hence we must look for the next best thing under the circumstances.

The most ideal way would be to procure another mother that could nurse the infant, but practically this is oftentimes impossible. She must be healthy, hide, bone and milk; free from tuberculosis, syphilis, and all the ills of woman. She must be kind, gentle and agreeable, and many other intricate nothings, besides being very expensive. Her own baby should be as near as possible to the age of the adopted one, and she willing to forsake her own and nurse another. Add all these

together and you have a problem about as difficult to solve as the proverbial needle's eye. And since artificial feeding can now be carried on according to the most approved methods, we find nursing the greater hazard. We must then turn our attention to feeding by hand, or, more properly speaking, artificial feeding.

The most used substitute amongst the laity and most condemned by the profession is condensed milk. This we find cheap, easy to prepare and will keep under most circumstances, and too, will generally agree with the baby, mostly because it is much diluted with water (breaking up the casein), the large proportion of sugar correcting the constipation (to which so many babies are subject) and producing an abundance of fat, soon making the baby big, round and healthy-looking. But clinically we find it very detrimental, the deficiency of proteids not being sufficient to supply the infant with heat and repair to carry it through the hardships of babyhood. Hence we find our children rachitic or scrofulous. It is good for travelling, in blizzards, or, where fresh milk cannot be procured, or temporarily in some forms of indigestion.

The second most used (because so well advertised) are the farinaceous foods. We find these differing very materially from milk. The different constituents are supplied not from milk, but from cereals, and contain not only the substitute ingredients of milk, but others as well, mostly starch. Hence, in the digestion and assimilation of these we have a newer problem. The starch must be changed to sugar before it again can be converted into fat. This is done by the admixture of the ptyalin found in the saliva and the amylopsin of the pancreatic juice. But as these are only secreted by the fourth month (some authors say third) it is useless to give before that time, or even afterward, because if it is partly cared for it cannot be digested entirely, and the remainder lies in the intestines and ferments, causing colic from accumulated gas, irritating the mucous membrane and producing diarrhœa, not only causing a drain of fluids, but also preventing a normal absorption, the excess of sugar depriving the albuminates of the oxygen, thus retarding necessary changes for the removal of waste. So, then, we find the proteids in excess, differing materially from proteids in cow's milk; the fats very deficient or entirely absent; sugar and starch in

excess, far more than is needed to supply all the wants of the babies' economy. Only in exceptional cases are the cereal foods of any use, and then only temporarily until the capacity of digestion is increased. They should be prescribed only as drugs. They are convenient, easy of preparation and cheap. The most common excuse that the cereals break up the casein in the milk and thus facilitates the digestion of the proteids, is not proved by experience; hence, as elsewhere, we often find temporary success to be ultimate failure.

In this class of patients we find: The feces more bulky, of a dried consistency, gluey in character, and by their odor give evidence of decomposition and undigested material. The urine becomes loaded with amorphous urates, uric acid and abnormal peptons and catarrhal condition of the bladder with its distressing symptoms often follow. The skin loses its clear, smooth surface, becomes roughened or even eczematous, the child is irritable, a poor sleeper and subject to catarrhal inflammation.

Our only solution, then, is to find the more perfect substitute. This, for many reasons, can only be *cow's* milk. But only after patient and persistent changes can it be used, because it differs so markedly in composition, not constituents, that it is necessary to get a definite idea of them to properly prepare the latter to be fit for the child's digestion, and we can arrive at them only by careful study of both the mother's and cow's milk. We find in comparison to mother's milk. The fat in about same proportion, the sugar less, but the proteids about double the quantity. To reduce the proteids we simply add water to get the required proportion, then supply the deficiency of fat from cream, and sugar, with a sugar of milk solution to bring to correct proportions. To this knowledge of quantities we must also know the method of preparation, modes of administration and means of preservation. For this modification the one most satisfactory and convenient is the Walker Gordon Laboratory's; but where cheapness is an important factor, we can modify it at home according to tables of mixtures and proportions too lengthy and bulky to here produce, but accessible in most any of the text-books on children's diseases.

Question then is, To what class of cases can we apply these principles? For more often we are obliged to introduce them when the baby is sick, as this is when we usually first see them.

The individual cases are those with diseases of the gastro-intestinal tract, and in no class of troubles is the attention to detail (and especially that of feeding) so necessary as here. The majority of cases having no nurse, we must depend upon a mother whose lack of training is a just cause of inefficiency. It is not enough to give directions, but we must see they are carried out. It is not enough to ask about the stools, but we must examine them ourselves, we must see the food and know that it is correctly prepared. When we realize that diarrrhœal diseases are responsible for more than 28 per cent. of infant mortality, we can realize what an enormous field of labor we have, and as this is an age of fewer children, we should endeavor to save the few that do finally reach this kingdom. We must first consider our patient, for it is not so much that the diseases are peculiar as it is the patients themselves are peculiar. Take, then, a sickly child with gastro-intestinal poisoning. Your first duty is to stop entirely all food from 12 to 48 hours, giving just plain water to allay thirst, or weak barley water, if the former does not satisfy it; or, if the child is in a very precarious condition, supply the wants of nutrition with egg albumin in water. Then after the intestinal tract has an entire rest, or better still, a thorough irrigation (both ends), we can begin the food, but only in the very smallest quantities and in the very weakest combinations. Thus, a six months' baby should be started on food suitable for a six weeks' baby, then gradually increasing quantity and strength as the baby improves, until we are feeding sufficient food of sufficient strength, changing at first as often as every week, later every two or three weeks, but always remembering that food is both curative and corrective. In fact, in many cases in which I have tried it I have given no medicine at all, merely minute powders of placebo. With proper care successes will far outweigh failures, and will well pay for the trouble.

We very seldom meet with a child that cannot be fed milk. But neither can we feed all cases alike, and often the food must be changed to correct the symptoms just the same as drugs, according to what experience has proved to us to be correct. For instance, if the amount of sugar is deficient, the gain in weight is very slow. If in excess, it causes colic, thin green stools, excoriated buttocks, eructations of gas and regurgitation of food.

When the fat is deficient, persistent constipation will follow ; when in excess, vomiting, regurgitation of small quantities of food, and fat in bowel movement. When the proteids are in excess, the stools are curdy and generally constipated, but sometimes a colic and diarrhœa will result. Or to change about. If the body is not gaining in weight, increase all the ingredients ; habitual colic can be prevented by decreasing the proteids ; frequent vomiting after feeding by decreasing the quantity. Vomiting small masses of food, decrease the fat, sometimes the proteids. For the obstinate constipation, increase both fats and proteids. Of course, the babies raised from the first on modified milk, or those that are not sick, require about the same directions and painstaking.

A MEDICAL MEDLEY.

BY FRED S. PIPER, M.D., LEXINGTON, MASS.

(Written for the Boston Hom. Med. Soc., November 2, 1899, Section of Materia Medica.)

THIS subject mentions briefly some experiences and observations concerning the usefulness of several remedies.

During my senior year in the B. U. S. M. I attended a case of cerebral meningitis in connection with Dr. George W. Crane. The patient was a male child, about one year old, in a poor family, living in a gloomy tenement. It was poorly nourished, and presented appearances of tubercular disease. The case passed through the stage of congestion under the administration of *Verat. vir.* 1x and *Bell.* 3x with no apparent effect from either. With signs of effusion *Bry.* 3x and *Apis* 3x were employed, but the child grew steadily worse until signs of fatal issue appeared. The eyes became dull, and power of vision seemingly impaired, and respiration was slow and irregular. *Hellebore* was selected as the best remedy, but with little expectation of changing the course of the disease at this advanced stage. The remedy was given in the 2x dilution in water every hour, and, to our great satisfaction, complete recovery followed. *Sulphur* 3x was later used to promote recovery.

This case illustrates what I have seen in two other cases in the last ten years, though both latter cases were less serious,

from the use of Hellebore, and it is the only use I have made of the drug. The case cited was probably not tubercular, as we suspected, but even then it was a serious condition to contend against.

Six years ago I was called in emergency to see a case of vomiting in pregnancy. The patient was 25 years old, and pregnant for the first time. She was a well-developed and previously healthy woman, living in a comfortable way in a healthy home. Vomiting had continued from the first month, and had increased in severity to the point of great exhaustion of the patient. She had been attended by one of my confrères, and on the day when I first saw her, a consultation had been held to consider the necessity of inducing abortion. She had retained no food for several days, and now rejected water. The case was distressing, if not actually serious. It was decided to delay abortion 24 hours, and try one more remedy, though what, I do not know, as I was not present. In the evening the husband came for me. The patient had grown worse since the time of consultation about noon, and the attending physician was away for the evening. I responded as a favor to the attending physician, and found the patient pale and weak, voice feeble, constant nausea, had retained no food for several days, and now vomited water. She was about ten weeks pregnant. I gave *Lobelia* 2x—twenty drops in half a tumblerful of water, with advice to give one teaspoonful every twenty minutes for one hour, and then every thirty minutes for an hour, after which it should be given once an hour. I allowed two teaspoonfuls of water to be given after one hour, and, later, a few swallows as often as desired. The next morning the husband called at my office to tell me that his wife was much better; the nausea and vomiting gradually subsided during the night, and she was now able to retain water. At his request, and after a fair understanding with the former attendant of the dominant school, I took the case, which was uneventful till in due time our efforts were rewarded by the birth of a healthy nine-pound boy. The nausea now and then returned, but was always readily relieved by *Lobelia* 2x. Such use of this remedy may be common practice, but I have not known of it. I now depend upon *Lobelia* more than any other remedy to relieve the nausea and vomiting in pregnancy, and

am very seldom disappointed. Certainly it serves me better than *Ipec.*, *Nux.*, *Tartar emet.* or *Verat.*, when nausea and vomiting are the principal symptoms.

For several years I have used tinc. of *Iodine* locally for infected small wounds and inflamed skin abrasions, and have reason to suggest its larger use in such conditions. Let me cite one case. A policeman had one thumb badly bitten by a drunken man he was arresting. The next day the thumb was much swollen and the wound looked angry, and it pained him severely. I painted the entire thumb with iodine and swabbed out each tooth-puncture by means of cotton on an applicator. With no further swabbing of the punctures, but two more applications to the surface, the thumb was restored to a healthy condition, and what had promised to be a serious septic wound promptly cured. Iodine thus employed seems to be absorbed and to neutralize the infection in the contiguous tissues and produce better results than strong carbolic acid or similar substances that cauterize.

The hands of a young lady were disfigured by small warts about the size of pin-heads. They were too numerous to be treated locally by salicylic acid preparations. One day a cat scratched her upper lip, and along the scratch a row of small warts appeared. Soon a group came on her forehead. I tried *Thuja* externally and internally, with occasional doses of *Sulphur*, for a month, with no noticeable improvement. Then I gave *Staph.* 3x, *Cal. carb.* 2x, *Graph.* 3x, in turn, with no effect. I was now led to give *Natrum sulph.* 3x for other conditions, with no thought of warts, but within two or three weeks the warts all vanished. Did *Natrum sulph.* disperse them, or did they disappear in consequence of tardy effects of some of the other remedies?

I have had very good results from *Cratægus* in one case where *Digitalis* and *Cactus* failed. The patient was a woman about 70 years old. She has had an intermittent pulse by spells for several years. When I first saw her the heart intermitted every third beat. She was short of breath on slight exertion, and felt anxious about herself. Her appetite was poor, and she was subject to frequent headaches. I could distinguish no abnormal heart-sounds except weakness.

Digitalis made the heart-action stronger, with an increase in

the quantity of the urine and some relief of headaches, but the intermittent pulse remained. *Cactus* apparently did nothing. *Cratægus oxy.*, in doses of five drops of the tincture, soon made the pulse regular, improved the appetite and relieved the dyspnoea, which *digitalis* had somewhat improved. I have used it in two other cases, one of mitral insufficiency and the other senile dilatation, with only slight benefit. I do not know of any proving of the drug. From the little that I know of the two remedies, *Quebracho* seems similar.

About a year and a half ago I was asked to treat a man seventy-four years old. He seemed to have chronic catarrh of the larynx and bronchi, with partial aphonia—severe coughing spells, profuse whitish frothy expectoration, and dyspnoea. Examination showed a serious aortic obstruction and mitral regurgitation, but I could hear no abnormal sounds in the right side of the heart. He had been treated for some time by a specialist with throat sprays and inhalations, to no effect. *Phos.*, *Sang.*, *Dig.*, *Arsen. iod.* and *Terpin hydrate* had little effect. A year elapsed and I could see no decided improvement, when he asked for treatment for retention of urine. It now appeared that he had been suffering in secret for two years with increasing difficulty in voiding urine. Examination by the rectum revealed a large, hard prostate, and the condition soon demanded the use of the catheter. As soon as the bladder was completely and regularly evacuated, the cough, expectoration and dyspnoea ceased. This may be a familiar experience to many, but I had not observed it before unless complicated by renal disease, which did not exist in this case. In the October, 1899, *HAHNEMANNIAN MONTHLY*, brief mention is made of five similar cases reported in a German medical paper and translated by Dr. Pritchard.

In closing, permit me to allude to the use of *Hydrastis* in hæmorrhage where it seems to act upon the unstriped muscle like ergot; to the great value of *Arsenite of Copper* 2x or 3x in uræmic intoxication and convulsions; *Quillaia* in coryza, and *Syringa vulgaris* to promote granulation in a manner like *calendula*. All my efforts at symptomatic prescribing in cases of chorea have been fruitful of results far less satisfactory than the use of Fowler's solution in three to five-drop doses.

Æsculus 3x has cured three-fourths of all cases of acute hæmorrhoids for which I have prescribed.

THE INDICATED REMEDY IN INTERMITTENT FEVER.

BY BENJ. K. FLETCHER, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

QUININE is used by many as the main remedy in intermittent fever. The old-school practitioner uses it because he knows of nothing better. But the homœopath has no such excuse. In his materia medica he has remedies that will not only stop the paroxysm as quickly as quinine, but will cure the disease in a superior manner. Under these circumstances it appears strange that so many homœopaths resort to quinine. I have no doubt that the majority use it from habit, a habit acquired in their younger days of practice. A young physician fresh from college is, of course, anxious to get quick results in order to gain a reputation, and not feeling sure of his homœopathic remedies, or of his ability to select and administer the correct one, naturally falls back on quinine, and so forms a habit from which it is hard to break away. Others, again, are too lazy to hunt for the correct remedy, and, taking that which requires the least mental effort, ladle out their quinine without regard to the misery they may cause the patient. Still others do not know enough to find the remedy. So quinine is their only resource.

In these cases of intermittent fever there is always more or less anæmia and gastric irritability, and these conditions are aggravated by the ingestion of quinine, even in comparatively small doses. The large doses that are necessary in order to stop a paroxysm are often followed by the series of symptoms known as cinchonism. Indeed it is not necessary to give large doses in order to produce this effect, as severe symptoms have followed the administration of remarkably small amounts. Delirium, coma, convulsions, and even death, have followed the taking of large doses, although happily a fatal result is of rare occurrence. These are not all the bad effects that follow the use of quinine, the continued use of which may cause urticaria and other skin eruptions, deafness, loss of vision, hæmaturia, etc. The ease and certainty with which we may stop an ex-

pected paroxysm and destroy the malarial parasite, as well as the automatic manner in which it may be prescribed, would make quinine an ideal remedy if we could eliminate its bad effects; but this does not seem to be possible.

The homœopathic remedies, however, with the exception that they cannot be prescribed so automatically, have all the good qualities, with none of the bad, ascribed to quinine. We can stop the paroxysm just as surely and cure the disease just as easily with our remedies as our old-school friends with their quinine, and with no bad after-effects; all it requires is a little study of our materia medica, and some effort at individualizing the cases. I will mention one or two that I have found particularly useful in Intermittents.

Arsenic is the remedy that I have found most useful in these cases. It corresponds very well to the anæmia and gastric irritability which are generally present, and in the absence of particular indications for another drug, I usually prescribe it on general principles. Of course such routine prescribing is open to criticism, but as long as the result is good I think that the objections cannot be serious.

Eupatorium perfoliatum I have also found useful in those cases in which we find the aching and pains in the bones prominent. This is a remedy frequently used by the old school for the same conditions, and also in domestic practice as the well-known boneset tea.

Nux vomica, *China*, *Gelsemium* and *Ipecac* have also proven very useful.

I have selected a few cases that were treated during the past year which show the excellent results that may be obtained with the homœopathic remedy. The first three cases were treated with arsenic, with excellent results.

G. C., female; April 6. Had chill, fever, and sweat on two previous nights. The paroxysm began about 9 P. M., and lasted for several hours. She had a burning pain in the stomach and diarrhœa. There were about five stools a day, which were dark and watery. She was anæmic and prostrated and had no appetite. A week later she reported no more chills or diarrhœa, and her general condition was much improved.

T. S., male; August 24. He has had a chill, fever and sweat every day for the past two months. The paroxysm begins about 3 P. M. He is anæmic, and feels tired and sleepy. Two weeks later he reported that he had been chilly only once since.

C. D., male; November 20. Had a chill, fever and sweat every other day for past two weeks. He was well in the intervals. He was given arsenic, and there was no return of the symptoms.

The next two cases were also treated with arsenic, but are interesting from the fact that they were first treated with quinine, which had aggravated the condition.

A. E., male; September 13. This boy was 13 years of age, and was born in the West Indies, where he lived until recently, when he came to Philadelphia. Soon after arriving here he was taken with a chill, followed by fever and sweat. There was some nausea and headache. These paroxysms recurred every other day. His father treated him with quinine, (amount not stated), which made him feel worse. He was given arsenic, and a prompt cessation of all symptoms followed. This was the first attack of malaria that he had ever had.

J. C., female; August 29. Had a chill, fever and sweat every other day for the past week. She took two grains of quinine three times a day, which caused nausea and vomiting. She has headache, is tired and languid, and has no appetite. She was given arsenic. There was no return of the symptoms until ten days later, when she had another paroxysm. The remedy was continued and there was no further return.

T. N., male; March 6. Has a chill every other day, followed by a short hot stage and a moderate sweat. In the intervals he has headache, aching in the back and limbs, and a pain in the axilla. He is languid and drowsy, and has no appetite. He was given Eupatorium, and immediately improved. There were no more paroxysms, and two weeks later he was well with the exception of his appetite, for which he was given Nuxvomica.

B. B., female; September 26. Had a chill, fever and sweat yesterday afternoon. This was accompanied by backache, toothache, and pains in the bones and eyes. The bowels were constipated. She was also given Eupatorium, and there was no return of the symptoms.

M. D., female; July 10. Two weeks before she had a chill, fever and sweat. She also had a paroxysm on the day before. She was well in the interval. She was given arsenic, and there was no return of the symptoms. Two months later she had a light attack of whooping-cough, for which she was treated. On December 2d, about five months after the first attack, she returned and stated that she had had chills every day for three weeks. The chill came at a different time each day, and was followed by a moderate fever and a profuse sweat. There was vomiting with the fever. Her appetite was variable, and there

was a burning pain in the stomach. The bowels were regular. There was also a cough with a slight whoop. She was given Iodide of arsenic. On the next day she had a slight chilly spell, but there were no other symptoms. At the last report she was well, with the exception of a slight cough.

W. C., male; December 6. Had a chill, fever and sweat on the day before, and also a week before that. He has nausea and vomiting every morning, and also a dull headache. The bowels are constipated. Appetite good. He was given *Nux vomica*. There were no more chills, and the other symptoms improved.

R. S., male; December 7. Two months ago he had an attack of malaria, and was treated by a doctor up the State. He then came to Philadelphia and obtained work in a mill. Three days ago he had a chill that lasted all the afternoon, followed by a short fever and a profuse sweat. There was pronounced nausea with the chill. He also complained of pain in the abdomen. His liver was enlarged and tender, and the spleen very much enlarged. He was given *Ipecac* and told to report in two days. He did so, and reported that on the day before he had another paroxysm of the same character, but beginning at 7 A. M. The remedy was continued, and there were no more paroxysms, and his general condition was much improved.

The last case I have to present to you is one I saw in the dispensary, but it was so very interesting that I thought that I would include it with the others.

The patient was a girl 14 years of age. On November 21st she came to the dispensary with the following history. A year ago she had malaria, from which she recovered, and has been well since, until a week before her visit, when she had a peculiar spell. It began with a chill lasting from 5 to 10 minutes, during which she laughed and cried hysterically. Then her feet and hands became as cold as ice, and her face flushed; she vomited, and her hands and feet contracted and relaxed, and she lost consciousness. This condition lasted about 3 hours, and was accompanied by a muttering delirium. She was very sleepy afterwards. She has had three such attacks, occurring every third day. She is thin and anæmic, has a poor appetite, and has constipation, alternating with diarrhœa. She had another attack on the next regular day, but had no more until December 4th, ten days later. Improvement continued until the 14th, when she had a mild attack. On January 6th she came in for an acute ailment, and reported that she had had no further trouble.

The paroxysm in this case was evidently a mixed one of malaria and epilepsy, the epilepsy being caused reflexly by the malaria. The patient was treated in that belief, with the excellent result noted.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE PERSONAL EQUATION.

IN the prosecution of our work we are often compelled to seek guidance and assistance from the results of the work of others, as given in recorded cases or in statistics. How often are we not met by the most unaccountable differences of opinion, or by irreconcilable contradictions? Statistics, even the most conscientiously gathered and compiled, only too often are found to lie, or, at least, to be capable of being used to prove directly opposite assertions. Our confusion and disgust would be limitless did we not remember that there is always an unknown factor, the personal equation, which must be taken into account. Its influence is sufficient in most cases to explain the vexatious differences which render the discovery of the truth so difficult.

The force of this personal equation is of course most evident in the narrations of personal experiences. We there often find recorded most brilliant cures of apparently identical conditions by means differing not only from each other, but also from those which we ourselves have employed with success, or would be likely to employ in similar cases. If we are not willing to acknowledge that diseased conditions can be removed with equal success by more than one remedy, we are thrown back on the supposition that the personal equation of the narrator has in some way affected the report of the case, or the conception of the cure effected. We know from observation that similar symptoms do not impress every observer alike, and what may appear to one of great importance may by another be lightly passed over, or even entirely disregarded. From this may arise the fact that reports which, on the surface, seem to represent identical conditions, in reality have reference to entirely different states or symptom-complexes. Here, of course, there is no difficulty in accepting the efficacy of different remedial agents.

Again, the ideas of cure, as to its rapidity and its completeness, also vary according to the personal equation of each individual. The one will vaunt his success in curing a case after a length of time which to another would be paramount to a confession of his utter failure to influence the course of the disease. Recovery is recovery, but not every recovery during a course of treatment can legitimately be called a cure. How often do we not find the personal equation asserting itself to such an extent that this difference between unassisted recovery and effected cure is entirely lost sight of?

Again, even the idea as to what constitutes a cure is modified by the personal equation of the observer, so that that which is reported by one as a cure leaves for another much to be desired. The thoroughness or completeness of a cure is thus also subject to decided difference of opinion.

Statistics having to do with these variable and uncertain elements are in their very nature also variable and uncertain. Besides this, the personal equation of the compiler of the statistics comes into play in the manner in which use is made of the recorded cases. They may be grouped according to some principle which does not or cannot meet with universal acceptance, but if analyzed and rearranged, they are just as liable thereby to become distorted representations of the true facts.

We can therefore hardly find in any of these means at our command a sure guide in our search for the truth. We are thus eventually thrown back upon ourselves and our own experiences, which in their turn are just as sure to be modified by our personal equation.

We were led to this train of thought by reading the numerous papers and statistics in reference to the use of antitoxine in the treatment of diphtheria, with which the journals of all schools are at present teeming. If we were not able to take refuge in the thought of the prevailing influence of the personal equation we would be obliged to say with David, in our haste, All men are liars. We find the most varied reports of the results of its use recorded with equal earnestness and apparent truth. We are willing to acknowledge that the criticism of the treatment by those who never employ it can only be directed against its claims to be the specific and only safe method. If they never employ it, this fact can surely be taken

as proof that they have not yet become discouraged by the methods which they have hitherto employed. Their experience may be limited, but as far as it goes, if it bears them out in their contention that they have cured and still can cure diphtheria without the use of antitoxine, they cannot justly be required, either by public opinion or by the present views ("subject to change without further notice") of their colleagues, to abandon its teachings. The idea that popular or professional clamor should ever be allowed to prescribe the method to be employed by a physician in the treatment of disease is, we think, derogatory to the profession. Would homœopaths generally be willing to allow it in the case of other diseases? Would we all be ready to abandon the use of our own remedies in the treatment of malarial fever for the much more universally recognized specific treatment with quinine? Could we not all point to cases where our remedies have been curative after quinine had proved ineffectual? Have we not all seen the rise and fall of many so-called specific treatments?

Of more weight are the opinions of those who have used and still do use antitoxine occasionally. They are in a better condition to compare results. Here, also, we find considerable variety of opinion. In the experience of not a few observers, equally as good results have followed the use of homœopathic remedies as have followed the employment of antitoxine. Those who use only antitoxine thereby confess that their previous methods have been unsatisfactory. This may have been owing to the insufficiency of these methods, but it is not unreasonable to suppose that in some cases, at least, the treatment itself was faulty. In reading the reports of many of the cases where the failure of the remedies which were used led to their abandonment for the easier and seemingly more successful use of antitoxine, we do not at all wonder that the results of the latter were more satisfactory. It is so much more simple and self-satisfying to have but one remedy to select, and to say, if that does not prove successful, that nothing could have been, than to endeavor to select according to our principle, out of a number, the one which corresponds to the case in hand. Were the results of antitoxine treatment invariably good, then would there be no room for doubt; but so long as its numerous failures find no better excuse than that it was not employed

early enough in the case, we surely are justified in denying that it is specific. The many cases where it has failed to relieve when used from the onset of the disease, or even before the diagnosis had been bacteriologically established, must count for something against it. We are then met with the explanation, however, that the dose was insufficient; but in regard to this very matter of the proper dose, the same personal variations are apparent.

In like manner, in the statistics we find no convincing proof that antitoxine has succeeded in lessening the mortality of diphtheria. The class of cases now included in the make-up of the statistics is quite a different one from that which formerly constituted the basis for estimating the mortality rate. Formerly it was clinical diphtheria alone; now it is clinical and bacteriological diphtheria which furnish the figures, and we all know that many cases of bacteriological diphtheria are without clinical symptoms, and recover with any or even with no treatment. The inclusion of such cases in the statistics will naturally show a lessened mortality, although the number of actual deaths from clinical diphtheria may remain the same.

The antitoxine treatment has not lessened the number of tracheotomies or intubations called for, and the better results of these operations at the present time are not necessarily to be ascribed to the previous use of antitoxine, since the marked improvement in the results of surgical operations in general must always be kept in mind.

Finally, when, with the use of antitoxine, the same remedies are employed which, before the introduction of this agent, have proved themselves able to cope with the disease, it seems illogical to ascribe all the good results to this newcomer.

We are, therefore, brought to the conclusion that not only have physicians and statisticians their personal equations, but that every case of diphtheria, and antitoxine itself, has its own personal equation, which needs to be recognized, and that, therefore, antitoxine is not *the* remedy for diphtheria, but only *one*, and no doubt a good one, of a number of others. Those who employ it in all cases should from their failures—and we know such do occur, although not always reported—determine the characteristics of the cases where it can reasonably be expected to give the surest results.

THE AMERICAN INSTITUTE WILL MEET AT WASHINGTON, D. C.,
JUNE 19, 1900.

THE fifty-sixth session of the American Institute of Homœopathy will be held at Washington, D. C., on Tuesday, June 19, 1900, and the monument to Hahnemann will be dedicated on Thursday afternoon, June 21, 1900. The local committee in charge being the resident members of the Institute.

This trio—the Institute, the monument and the Washingtonians—is a combination that cannot be excelled, and although the time for preparation is not two months, the meeting of June 19th will be the most interestingly successful one in the history of the Institute. The great central feature of this meeting will undoubtedly be the monument to Samuel Hahnemann, the founder of Homœopathy. It will be the crowning act of the century, and the culmination of the hopes and ambition of that devoted band who conceived and carried to successful completion the most magnificent monumental memorial ever raised to a medical man in the world.

It is desirable that every member of the Institute, and every friend of homœopathy who contemplates a pilgrimage to the National Capital, next June, to witness the unveiling of the monument honoring Hahnemann and his great life-work, should clearly fix the date of the sessions, June 19 to 23, 1900, otherwise the premature announcement of an early date (June 5th) by some of our representative journals will be misleading. We considered the earlier date the more desirable, but those in charge found insuperable difficulties in the way, and were unwilling to assume the responsibility of assuring the Executive Committee of the Institute that final arrangements would be completed for the dedication on June 7th, and they wisely deferred it to two weeks later, June 21, 1900.

The local Committee of Arrangements is at work, and members of the Institute who attended the forty-eighth anniversary held at Washington, D. C., June 13 to 17, 1892, know exactly what this means, and nothing will keep those living from being present at the 1900 meeting to enjoy the fruits of their untiring zeal and devotion. The Executive Committee consists of:

Wm. R. King, M.D., *Chairman*, 1422 K Street, N. W.; L. B. Swormstedt, M.D., *Treasurer*, 1455 14th Street, N. W.; Ralph Jenkins, M.D., *Secretary*, 1732 Massachusetts Avenue, N. W.; J. B. G. Custis, M.D., Monument Dedication; F. A. Gardner, M.D., Finance; Z. B. Babbitt, M.D., Entertainment; S. S. Stearns, M.D., Halls and Theatres; W. F. Corey, M.D., Decorations and Badges; R. Kingsman, M.D., Printing; I. W. Dennison, M.D., the Press; C. A. Davis, M.D., Hotels; H. Krogstad, M.D., Transportation and Post-office.

The work of this committee, as far as completed, arranges for the meetings to be held in the large banquet halls of the Hotels Arlington and Shoreham. All business sessions will be held at the Arlington, and the Sectional meetings will be divided between the Arlington and the Shoreham. These hotels are half a block apart, and are the best American-plan houses in the city. A rousing opening meeting will be held at the National Theatre on Tuesday evening, June 19th, with music, Presidential Address and brief speeches. The monument will be dedicated on Thursday afternoon, June 21st, with an exceptionally interesting programme, with several prominent speakers, the Marine Band, etc.

The Eye and Ear Society will meet in Washington, Saturday, June 16th, and Monday, June 18th, at the Hotel Shoreham, and the new Surgical Society will hold its sessions Monday, June 18th, and Tuesday morning, the 19th, at the Arlington Hotel.

The Cleveland members of the Institute, who worked so earnestly and successfully at Atlantic City last year for the 1900 meeting, gracefully yielded their claim as soon as they were assured by the Monument Committee that they were ready to erect the monument. While this was the gracious and proper thing for them to do, they were none the less disappointed in failing to have the Institute meet at Cleveland this year. It is probable that if they renew their invitation for 1901 it will be accepted by the Institute.

It has become evident that the year 1900 is the proper time to build and dedicate the monument to Hahnemann. The profession must realize that it is also the year, and June is the month, to *pay* for the monument to the last cent due. It is no longer a matter for discussion or criticism, everything has

been done in order and decency, and with excellent judgment. The one thing remaining to be done is to pay the outstanding bills, some twenty thousand dollars. The homœopathic profession of the United States stands pledged to the world to pay this sum. As a member of the profession you are pledged. You cannot escape your responsibility. You may shirk and you may throw your share on others, but you cannot maintain your self-respect without doing your part in proportion as you have been favored with success. Each doing their best, the amount needed will be easily raised by June 1st. Send your contributions to H. M. Smith, M.D., 288 St. Nicholas Avenue, New York City, Secretary of the Hahnemann Monument Committee, or to George G. Shelton, M.D., 521 Madison Avenue, New York City, Chairman of the Hahnemann Finance Committee. In addition to your own subscription, interest your patients. Dr. J. H. McClelland reports a successful example—Mrs. George Westinghouse, Pittsburgh, recently contributing one thousand dollars. And a well-known Philadelphia surgeon last week, by asking his friends, doctors and laymen, raised another thousand. You likewise can raise a hundred or more. What is needed is for you to make the effort.

ETHER NARCOSIS BY THE RECTUM.—Calderon, San Francisco, has adopted the following device for the administration of ether by the rectum.

A cylindrical vessel containing about two quarts of water, having on the inside a tube which commences at the bottom, passing up and out, connecting with a small funnel. Opposite this and on upper wall is an opening and tube to let out the overflowing water. Between these tubes there is on the wall a cut one and a half inch wide, running almost the whole length of the vessel and hermetically sealed by a glass plate; behind this a thermometer is attached. A small device inside the vessel supports the ether flask. The cover has another opening in centre, through which extends a rubber tube, joined to the ether flask, about two feet long; to this tube is attached a faucet and hard-rubber nozzle, the latter to be inserted into the rectum. Pouring into the vessel and through the funnel water of 105° Fahrenheit, the ether fumes are perceivable coming through the nozzle after opening the faucet; the etherization can then begin. At a lower water temperature the ether would evaporate very slowly, and at a higher one it would boil.

The evening before an operation the patient requires a physic and a water enema, which should be repeated one or two hours before operating, all of which is necessary to obtain a successful narcosis.—*Pacific Medical Journal*, March, 1900.

GLEANINGS.

A CRITICAL STUDY OF THE JUSTUS BLOOD-TEST FOR SYPHILIS—(Jones, New York).—This test is based on the asserted fact that a single inunction of mercury in all untreated cases of secondary, tertiary and congenital forms of syphilis causes a reduction in the hæmoglobin, due to the sensitiveness of the red-blood corpuscles to the action of this drug, while in non-syphilitic no re-action follows.

He gives his deductions in thirty-five syphilitics and eighteen control cases. The Justus test has a value in the recognition of doubtful cases of syphilis, although it is not infallible. The test often fails in cases in which a diagnosis is especially desired, viz., latent cases and early chancre, and sometimes at the beginning of the secondary stage. It has only a positive value.—*N. Y. Med. Journal*.

Herbert P. Leopold, M.D.

THE TREATMENT OF GOUTY DEPOSITS—(McGinnis, New York).—He makes use of cataphoresis, or electrical osmosis, for the purpose of applying lithia, which has for a long time been known to dissolve the concretions of urates, and phosphates with some lime, directly to the affected joints. His technique is as follows: The joints are first prepared by sponging with chloroform, the idea being to dissolve the fat and sebaceous matter. Thin sheets of sterile cotton are wrapped around the joints and thoroughly wetted with a solution of the iodide of lithium. They are covered with metal handles of the galvanic battery and attached to the positive pole, the other hand is laid on a flat metal plate attached to the negative pole. From fifteen to twenty-five milliampère are then turned on. The current is applied from eight to ten minutes. On the removal of the electrodes and cotton the joints are massaged for several minutes more, with the idea of forcing in all the salt possible. This is done daily; marked improvement may be expected after the third treatment. However, this must be continued until all tenderness has gone.—*N. Y. Med. Journal*.

Herbert P. Leopold, M.D.

PURPURA FROM IODINE ON THE MUCOUS MEMBRANE OF THE MOUTH.—Dr. G. Milian observed a woman of forty-two years, who, after taking six gms. of the iodide of potash for six days, noted a large, red ecchymosis on the hard palate, surrounded by several smaller suggillations, while at the same time there was a burning sensation locally. The exudate from the ecchymoses was a homogenous, sanguinolent fluid, without inclination to coagulate, and resembling the hemorrhagic mucus of hysterics. After discontinuing the drug the eruption disappeared, but reappeared as soon as it was taken again; there were also other signs of iodism. Neumann, of Vienna, has recorded a similar case where the iodic exanthem appeared near the pylorus in the mucous membrane of the stomach.—*Hospitalstidende*, No. 48, 1899. Iodic purpuric erup-

tions on the skin of late years have become quite well known, yet it is only a few years ago that a Scotch writer reviewed our knowledge on this and called attention to its comparative rarity. I have employed the iodide of potash in angry reddish wheals of an urticarial nature, where they seemed to be dependent on a septic poison, and with good results.

Frank H. Pritchard, M.D.

ENLARGEMENT OF THE SUPRACLAVICULAR GLANDS IN THE DIAGNOSIS OF ABDOMINAL CARCINOMATA.—Dr. C. Tarchetti, having observed a carcinoma of the liver, with metastases in the pancreas in which the supraclavicular glands were affected and carcinomatosely degenerated, has studied the diagnostic value of this glandular swelling, and particularly on the left side, which value has been emphasized by some and neglected by others. After careful examination of the evidence, he concludes, though not frequent, it should be sought for in suspected abdominal cancer. It may be present not only in carcinoma of the stomach, but also of the duodenum, liver, and also possibly of other abdominal organs, as the pancreas, without the stomach being the least affected simultaneously. It may appear at any period, even at a very early stage, when it may be of pronounced value diagnostically. A metastasis to the supraclavicular glands presents a characteristic picture, and, microscopically, the changes are easily recognized. A slight enlargement and induration of the cervical and inguinal glands is very usual in carcinoma, but it is not generally due to a metastasis, and is of no diagnostic importance.—*La Settimana Medica*, No. 48, 1899. This sign is not nowadays recognized as of as great diagnostic importance as a few years ago. The enlargement may be dependent upon other diseases than carcinoma, as for example syphilis or tuberculosis. Still, Lépine diagnosed a case of cancer of the stomach very early by this sign.

Frank H. Pritchard, M.D.

HÆMORRHAGIA CEREBRI POST COITUM.—Dr. Scheiber mentions the case of an old bachelor of forty-six years, who "während des Coitus in einen Bordell," was stricken with apoplexy and became insensible. He was taken home in a carriage, his address being gathered from papers on his person. He returned to consciousness and presented a very marked right-sided hemiplegia. This was treated by electricity, which was of little service; the upper and lower extremity became contracted, and some years after he was noticed going about with the same contractures.—*Deutsche Medicinische Wochenschrift*, No. 50, 1899. Prof. F. Gumprecht—*Ibid.*, No. 45, 1899—reports a similar case in full. Some years ago such a case was mentioned in *La Semaine Medicale*.

Frank H. Pritchard, M.D.

ILEUS AND ATROPINE.—Dr. Batsch is a warm advocate of hypodermic injections of large, and if necessary very large, doses of atropine in ileus. Proceeding from Murphy's assertion that dynamic (Schlange's) ileus is due either to a paralysis of the motor fibres of the splanchnic nerve—adynamic form—or to an activity of the inhibitory nerve-fibres, the dynamic variety, in a very serious case of ileus, with violent singultus, he tried atropine hypodermically in order to relieve the spasm of the inhibitory splanchnic fibres. After two subcutaneous injections of five mgms. an enormous evacuation followed, with recovery. Also in other cases of most serious obstruction of the bowels, as in incarceration of a large scrotal hernia, injections of atropine brought about a recovery.

The remedy should not be employed as a routine measure, for other and milder means may succeed, but it is possible to use it where an operation is contra-indicated or impossible, and the gravely threatened or almost lost life may yet be saved. It is applicable even in the most aggravated state of collapse.—*Muenchener Medicinische Wochenschrift*, No. 45, 1899. I have employed hypodermic injections of atropine and morphine as a preliminary measure in incarcerated hernias before employing taxis, and with very satisfactory results. In scrotal and umbilical as well as crural hernias, which were absolutely immovable before injecting, after this measure, and waiting fifteen minutes to half an hour, the hernia would often slip in with great ease. The older surgeons used an infusion of belladonna per rectum in these cases. In the same journal the same writer mentions a similar case successfully treated by a colleague. In the same journal, No. 51, he cites two further cases, one very instructive. Mrs. S., a farmer's wife of twenty eight years, with a rachitic pelvis, and who, a primipara in labor, required craniotomy, and which was followed by a tedious and long-lasting extraction of the child. After four days no stool, when thin and yellowish fluid was vomited; great tympanites and not even flatus was passed. On the morning of the fourth day two mgms. of atropine were injected. Up to nine that evening no relief. Then on his own responsibility, as his colleague would not assume a part of the same, he injected five mgms. (0.005) of atropine again, the patient being in the most extreme degree of collapse. The following morning the abdomen was soft, a great deal of flatus had been passed, and she was greatly relieved. There had been slight delirium during the night. The vomiting had wholly ceased. Five mgms. more of the remedy were injected; that forenoon slight delirium, and at noon a moderate stool. The patient recovered without a rise of temperature.

Frank H. Pritchard, M.D.

SOME NERVOUS COMPLICATIONS OBSERVED DURING THE EARLY STAGES OF BRIGHT'S DISEASE (*Petit Brightisme of Dieulafoy*).—Dr. Maurice de Fleury calls attention to the pre-albuminuric or initial symptoms of chronic Bright's disease, which have been described by Dieulafoy as the "minor symptoms" of Bright's (*petit brightisme*). He details the history of four patients presenting fatigue in the limbs, *very great arterial tension*, voracious appetite, poor digestion, somnolence by day and insomnia by night, fornication, "dead fingers," scanty urine, which was below the normal in extractives (*hypotoxique*) as well as slightly albuminous.

They were affected with: the one with right-sided hemiparesis, with disturbances of speech and even transitory aphasia; the second, with melancholy, with ideas of persecution; the third, with mental confusion and melancholy; the fourth, with epilepsy (*petit mal*).

None of these patients were ameliorated by the ordinary treatment for these three affections, while, on the contrary, all were greatly improved by milk diet, aided possibly by injections of pilocarpine. The symptoms reappeared on leaving off the milk. Therefore, he feels justified in concluding them due to uræmic poisoning, the cerebral symptoms being dependent upon a "petite urémie nerveuse." The non-recognition of these states, which frequently are associated with but *very little* albumin in the urine (or none at all), may "expose the practitioner to mistakes in diagnosis and therapeutic failures." The chief aids to diagnosis are the high blood-tension and the urinary toxicity.—

Le Progrès Médicale, Nos. 48 and 49, 1899. These very interesting cases should be read by those who have access to this journal. One meets with so many cases of chronic kidney disease in both young and old, and particularly in the ageing individuals of any community. To be able to recognize these minor symptoms of oncoming Bright's will show one a glimpse of the future which may be of vast aid. I personally have met with so much of this disease. Our present ways of living tend to develop it. The mental symptoms of Bright's are among the little understood things of medicine. The French writers have particularly studied them. Goodno calls attention to them in his excellent work, *Practice of Medicine*. A later work by Clifford Albutt, *System of Medicine*, goes still more deeply into the subject. Prof. West, of London, in his Lettsomian Lectures on "Contracted Kidney," which, by the way, are the best contributions to practical medicine that I have read in many a day, dwells strongly on these cerebral disturbances of uraemia. I had many unpleasant experiences from such cases being misunderstood by others. One cannot expect to use a little nitric acid and diagnose chronic contracted kidney in its varied forms.

Frank H. Pritchard, M.D.

SODIUM PHOSPHATE IN URTICARIA.—Dr. B. Wolff recommends doses of four to five grams ($3j-\frac{1}{4}$) of a saturated solution of sodium phosphate every three hours in the distressing itching of urticaria as sufficient to relieve in a few hours and to cure in twenty-four. Also in children with nettle-rash, accompanying gastric affections, in a corresponding dose it acts fully as well; in the chronic variety it also alleviates, but with the tendency to recurrence it must be taken for some time to prevent a relapse.—*Wiener Medizinische Presse*, No. 50, 1899. In this disease I have found, as Hughes says, "grain doses of chloral, of late, sufficient." It is an excellent sedative in itching skin diseases. The iodide of potash is another very useful remedy in certain forms of urticaria, particularly where the wheals are reddish or purplish and associated septic affections.

Frank H. Pritchard, M.D.

GOITRES SECONDARILY EXOPHTHALMIC (*Le Goitre Basedowifé*).—Dr. Morestin has recently observed two cases of goitres primarily simple, which, after years' duration in the first, and after confinement in the second, commenced to develop the symptoms of Basedow's disease. After extirpation of a little tumor, which had begun to grow with the development of exophthalmic symptoms, these latter disappeared. In the second, in a woman of thirty-one, who had had a goitre from childhood, the characteristic symptoms of Basedow's disease began, and though extirpation was done with temporary relief, yet, from it being impossible to remove all the gland, the pulse again became accelerated and the mind somewhat affected.—*Journal des Praticiens*, No. 49, 1889. I know of such a case. Gerhardt calls attention to the relatively slower pulse in children, and the possibly later appearance of the staring eyes (glotzaugen), with Basedow's disease. In such a case, in a girl of nine years, after the rapid heart, the prominent eyes (slight), and cardiac murmurs at all four valvular orifices with anæmia had persisted for several years, a small goitre developed.

Frank H. Pritchard, M.D.

A SPECIAL PSEUDO-PERITONITIC SYMPTOM COMPLEX AT THE TERMINAL STAGE OF ADDISON'S DISEASE.—Prof. W. Ebstein, in five cases of Addison's

disease, calls attention to the difficulty of diagnosis of certain forms. Usually easy in the typical cases with (1) melanoderma, (2) the profound asthenia, and (3) the cachectic phenomena. In unpronounced cases one must follow them for a time to be able to exclude (a) pernicious progressive anæmia, (b) leucæmia, and (c) latent pulmonary tuberculosis.

In the terminal stage such patients show great sensitiveness of the abdomen to palpation, with vomiting, which might lead one at first to diagnose peritonitis. Though usually the pains are in the lumbar region and the vomiting in the morning like that of drunkards, here the least pressure causes intense pain, which may be diffuse, localized in the epigastrium or in one side of the abdomen. The abdominal muscles are strongly contracted, the belly rather hollowed out than distended; no fever; no constipation nor diarrhœa. In age the patients varied from twenty-seven to forty-six years. Some were still somewhat strong and tolerably plump, and only two were bronzed. The necropsies revealed caseated or atrophied suprarenals.—*La Semaine Médicale*, No. 53, 1899. Arsenic and silver both will cause such a coloration of the skin. There is a variety of diabetes which has been studied particularly by the French writers (Hanot, etc.), associated with a peculiar bronze coloration of the skin, but also with an enlarged liver and sugar in the urine (diabète bronzée). Cancers of the pancreas may also be the cause of similar discoloration of the skin. Osler goes into this subject quite thoroughly. Eichhorst (*Lehrbuch der Praktischen Medicin*, p. 411) states that he has seen such patients suddenly become comatose and die in this state. In some cases without the bronzed skin the necropsy only will reveal the cause of the general symptoms and final fatal coma (diseased suprarenals).

Frank H. Pritchard, M.D.

THE DIFFICULTY OF DIFFERENTIATING BETWEEN CANCER OF THE LIVER AND HEPATIC CIRRHOSIS AT THE TERMINAL STAGE.—Dr. Landieux, though admitting that a differential diagnosis between these two diseases is in general easy, yet many times when such cases in the terminal stages come under the observation of hospital physicians they closely resemble each other; for in both there are not only the clinical picture of cirrhosis or of cancer, but also of the "hepatic cachexia," due to destruction of the parenchyma of the liver. The duration will not always aid, for there are cases of rapid cirrhosis, of which he reports a case, and in cancer, enlargement of the supraclavicular glands are not frequent. Nevertheless, the sub-delirious state of the patients, with the results of palpation of the liver after withdrawing the ascitic fluid by puncture, when a cirrhosis may be distinguished from a cancer with disseminated nodules. On the contrary, to distinguish between an hypertrophic cirrhosis and a primary cancer, whose surface is uniformly smooth, is not easy.—*Journal des Praticiens*, No. 47, 1899.

Frank H. Pritchard, M.D.

TREATMENT OF CARDIAC INSUFFICIENCY WITH GENERAL ARTERIO-SCLEROSIS.—Dr. Carrieu, where digitalis does not seem indicated in general arterio-sclerosis, and with associated valvular mitral insufficiency, advises the following combination: Iodide of potash, 0.5-1.0; sulphate spartein, mixtura gummosa, 90.0, and syrup of orange peel, 30.0. To be taken in the course of twenty-four hours.—*Wiener Medizinische Presse*, No. 52, 1899.

Frank H. Pritchard, M.D.

AN ELIGIBLE PREPARATION OF SALICYLIC ACID.—In cases in which salicylic acid and its derivatives are badly tolerated, Dr. H. Habermann (*Deutsche Med. Wochenschrift*, No. 8, 1900) has for six months employed aspirin, or acetyl salicylic acid. His clinical material comprises seven cases of acute and subacute articular rheumatism; five cases of recurrent chronic articular rheumatism; one case of purpura rheumatica; several cases of chronic gout; a series of cases of rheumatoid pains accompanying colds, angina and influenza; and finally in several instances of neuralgia of the face and intercostal nerves. The dose was usually 15 grains, and was given either dry on the tongue, followed by a drink of water or other fluid, or in wafers. The maximum daily dose was 60 grains. The results were very satisfactory, the pains being promptly allayed, often after a single dose the fever disappearing, while the swelling of the joints and the acuteness slowly subsided. In the chronic cases, especially gout, 15 grains were administered morning and evening, and after a time only in the evening, with the result that the pains were relieved or checked, enabling the patient to enjoy undisturbed sleep. In most instances aspirin was well tolerated without gastric disturbances, tinnitus, or vertigo. Sweating was sometimes observed after large doses, but was never as profuse as with equal doses of other salicylic preparations. In two cases, where undoubted idiosyncrasies existed against sodium salicylate, as manifested by nausea and vomiting, aspirin was very well borne, with restoration of the appetite.

GASTRO-INTESTINAL DISTURBANCES DUE TO GENERALIZED ARTERIO-SCLEROSIS.—Dr. v. Engelhardt asserts that in generalized arterio-sclerosis, before the visceral localizations have had time to develop, certain gastro-intestinal disturbances, dependent on vaso-motor states, and consisting of gastralgic and diarrhoeic crises, are noted as premonitory signs. The pains most always appear at night or after eating, if the patient does not remain quiet during gastric digestion. Lying down is disagreeable, and the patients prefer to be up and about, and make attempts to relieve themselves by forced eructations. The abdominal aorta and the iliac vessels are sensitive to pressure. A change in diet does not appear to affect these pains, which, on the contrary, yield to the double salicylate of soda and theobromine. As to the diarrhoea, it usually comes on in the morning, and the stools are thin and serous. It yields to the iodide of potash with caffeine.—*La Semaine Medicale*, No. 55, 1899. In some cases dyspeptic symptoms precede heart insufficiency, both being symptoms of abdominal stasis.—Edgren, *Kliniska Studier öfver Arterioskleros*, p. 256, 1897.

Frank H. Pritchard, M.D.

CHANCER OF THE FINGER PRODUCED BY A BITE.—Dr. Popée observed a man at the hospital in Lemberg who had a chancre on the little finger of the right hand, with the general signs of recent syphilis; the roseola was very pronounced, and there were mucous patches in the mouth and about the genitals. The chancre had appeared after the patient had been bitten in a brawl by a companion who had been under treatment, at the same hospital, for syphilis. On both the dorsal and palmar surfaces of the finger there were two classic hard chancres, with infiltrated borders and bases. Besides, there was an enlargement of the cubital glands.—*Przegląd Chirurgiczny*, Tom iv., Zeszyt 3, 1900.—(Chancre of the finger in physicians has been noted.)

Frank H. Pritchard, M.D.

CONICAL STUMP AFTER AMPUTATION IN CHILDHOOD.—Powers (Denver) calls attention to this point, which has been neglected hitherto, particularly in our text-books. It is this: "After amputation through the upper part of the arm or the upper part of the leg, in childhood, a slow development of a conical condition is physiological, and is to be expected. This is quite independent of the nature of the stump after the original amputation. It is because the humerus and the leg bones are developed in large part from their upper epiphyses. The growth takes place after the amputation, and simply pushes the bone through the soft parts. The principle is a fixed one, and should find a place in our text-books, and should be taught to students." The author gives some excellent photographs of a case which came under his care.—*Annals of Surgery*, April, 1900.

Gustave A. Van Lennepe, M.D.

EXCISION OF THE EXTERNAL TWO-THIRDS OF A GASSERIAN GANGLION BY THE HARTLEY-KRAUSE METHOD, AFTER PRELIMINARY LIGATION OF THE EXTERNAL CAROTID ARTERY.—Spellissy (Philadelphia) recommends ligation of the external carotid artery as a step preliminary to the Hartley-Krause method of excising the Gasserian ganglion. In the case reported the ligation was done near the angle of the jaw and above the hypoglossal nerve. The aim was to tie above the facial and occipital arteries. This proved a most valuable aid in preventing middle meningeal hæmorrhage, and allowed of a removal of the external two-thirds of the ganglion at "one sitting." It is pointed out that in order to prevent the loss of jaw and cheek control, and also a subsequent loss of the eye on the affected side, the first or ophthalmic branch as well as the internal third of the fibres of the ganglion should be preserved.—*Annals of Surgery*, April, 1900.

Gustave A. Van Lennepe, M.D.

ON THE USE OF FIXATION-PLATES IN THE TREATMENT OF FRACTURES OF THE LEG.—Steinbach (Philadelphia) calls attention to the value of the Roentgen rays in revealing displacements of fractured bones, and cites four cases of fracture of the leg, in which the knowledge thus obtained was made use of, and the deformity reduced by the open method. To hold the bones in position, silver plates are used, fastened on each side of the line of fracture by means of two small galvanized steel screws. The plates are one-sixteenth of an inch in thickness, three and one half inches in length, and three-fourths of an inch wide, with perforations for the screws one half inch apart. They are applied to the flat subcutaneous surface of the tibia, over the periosteum. If infection exists, or may be expected to supervene, counter-openings are made and the wound drained; otherwise the latter is closed by interrupted silk worm-gut sutures.

At the end of about one week the limb can be placed in an immovable dressing and the patient allowed to get up on crutches. The plate seems to be a harmless tenant in the leg, and is permitted to remain in position until bony union has taken place. Its removal is accomplished with the aid of local anaesthesia alone. The screws are found to sit firmly in the osseous tissue.—*Annals of Surgery*, April, 1900.

Gustave A. Van Lennepe, M.D.

THE AFTER-TREATMENT OF SEVERE LAPAROTOMIES (Fritsch).—Death after laparotomy depends especially on the weakening of the vital forces, and pains should be taken not to depress them by the preparatory treatment or by vio-

lent action of cathartics. The subjective conditions are the most important after operation. Peritonitis is not a cardinal symptom of sepsis. Danger comes in days and hours, not suddenly. An experienced nurse and rest are very important. Salt water infusions should be made in severe operations before the ether is stopped. It is important to maintain the temperature of the body. Heated operation-tables are unnecessary. Douching with hot water has a good effect, but should not be used except at the time of operation. Warm enemata are the best, about 100 gr. every two hours. Warming apparatus for the direct application of heat is to be recommended. The stomach should be empty for the first forty-eight hours. Quinine is a good remedy for fever. The stool is of little importance. Cathartics will not prevent adhesions or loosen them.

This last expression from such an authority will not find much support among American operators. Early catharsis promotes peristaltic action of the intestines, and prevents the collection of gas which adds greatly to the distress of the patient, and by the distention of the intestines and thinning of its wall increases the risk of infection or the absorption of toxins from the bowel.—*Monatsschrift für Geburtshilfe und Gynäkologie*, October, 1899.

George R. Southwick, M.D.

RUPTURE OF THE SYMPHYSIS DURING A DIFFICULT EXTRACTION WITH THE FORCEPS (Jellinghaus).—The patient complained immediately after delivery of pain in the region of the symphysis, and inability to move the legs. Moderate hæmorrhage continued after the expression of the placenta. The legs were rotated outward. The region of the symphysis was extremely sensitive, and through the external uninjured skin the ends of the symphysis could be felt separated four or five centimeters, the right a little lower than the left. Inspection of the genitals revealed a tear five cm. long extending high up along the right anterior vaginal wall by which the soft parts of the vulva in their upper half were almost entirely torn away from their bony attachment and formed a hanging fold.

There was an irregular cavity, nearly the size of a fist, at the site of the tear, bounded above by the base of the bladder. The external orifice of the urethra, which had been entirely torn away from the symphysis, had greatly retracted, and could not be found till after the cavity was cleared of clots and was somewhat mangled.

The vaginal tear was considerably diminished by catgut sutures and the cavity remaining packed with iodoform gauze and a permanent catheter introduced. The pelvis was immobilized with three strips of adhesive plaster, which fixed the pelvic ring securely. It was occasionally renewed and well borne. The lying-in period was normal apart from fever caused by cystitis.

The urine escaped spontaneously on the twelfth day. The cavity closed in six weeks, and examination at the end of seven weeks showed firm bony union of the symphysis.

Walking, which was begun at this time, was painful in both lower extremities, especially in the hip joint, but not in the symphysis, from which she made gradually a good recovery.—*Centralblatt für Gynäkologie*, No. 43, 1899.

George R. Southwick, M.D.

THE TREATMENT OF POSTOPERATIVE HÆMORRHAGE OF CÆLIOTOMY.—Dr. Reed recommends tying the bleeding point as soon as possible. Dr. Hall

mentions the difficulty of diagnosing hæmorrhage and shock, and if the operation was of a character to make such a hæmorrhage probable, a stitch or two can be removed to facilitate diagnosis, with the aid of a long *silver* probe introduced in different directions. Dr. Carstens believes in the efficacy of atropine or belladonna in preference to strychnia. Dr. L. H. Dunning finds an irregular capillary circulation or congestion here and there—a valuable diagnostic sign of shock. Dr. Werder states that one rule in patients suffering from secondary hæmorrhage is that they have a rapid pulse, lowered temperature, restlessness, etc. The temperature is not important. The pulse is important, and if it gradually rises ten beats or more after operation there is hæmorrhage, no matter what the temperature may be. Tying each vessel separately instead of ligature *en masse* is most valuable in avoiding secondary hæmorrhage.

George R. Southwick, M.D.

VENTRO-SUSPENSION OF THE UTERUS BY THE ROUND LIGATURES (Gilliam).

—The principle of the operation is invagination of the proximal portion of the round ligament in the abdominal, and is outlined in the following steps:

1. The usual median abdominal section.
2. Break up adhesions and bring the fundus forward.
3. Seize and bring the Fallopian tube to the opening so that the corresponding round ligament can be seized and lifted up an inch and a half from the uterus.
4. Carry a heavy silk thread under the ligament close to the forceps in such a manner as to include a little of the tissue of the broad ligament with an aneurysm needle or ligature carrier. This loop is not tied, but the ends of the thread are brought out and secured in the bite of a snap forceps.
5. The forceps holding the tube and round ligament are now removed.
6. The opposite side is treated in like manner.
7. Retract the skin and superficial fat on one side until an inch or more of the rectus is exposed, so as to expose a point through which a sharp-pointed forceps can be thrust into the peritoneal cavity one inch external to the margin of the wound and an inch and a half or two inches above the pubis.
8. The above-mentioned forceps are thrust through and made to seize the thread holding the round ligament, and the clamp forceps on the ends of the thread are then removed, and the forceps are withdrawn, carrying the thread, and in turn the ligament, through the perforated wound in the abdominal wall.
9. The ligament is now held taut and fastened into the wound with catgut sutures.
10. The exposed free loop of the ligament is now spread out on either side of its point of emergence and tacked down with catgut, so as to form a button or bar, to prevent retraction.
11. The opposite side is treated in the same manner and the abdominal incision is closed.—*American Journal of Obstetrics*, March, 1900.

George R. Southwick, M.D.

THE TREATMENT OF INTESTINAL DISTENTION AFTER CÆLIOTOMY (Baldwin).

—The writer advocates a generous dose of Epsom salts just before operating, and a single large dose of calomel in a capsule twelve hours after operating, in preference to small doses or triturates of the same remedy. At the very first sign of distention of the large intestine high enemas are given and continued

until gaseous or faecal movements are secured. He recommends as especially valuable a high enema, well above the sigmoid flexure, of two ounces of Epsom salts, one ounce of glycerine, and three ounces of water. This has produced results when everything else has failed.

George R. Southwick, M.D.

A NEW METHOD OF TREATMENT OF DIFFUSE SEPTIC PERITONITIS (Fowler).—Nine consecutive cases of recovery are reported. The treatment consists essentially in elevating the head and trunk to facilitate drainage into the small pelvis, combined with the thorough use of wicks of gauze deeply placed in the abdomen to facilitate capillary drainage through the abdominal wound. Twenty-one wicks were used in one case. The object is to collect the septic fluids at the most dependent portion of the peritoneal cavity, where there are the fewest lymphatics to absorb it into the system. Meantime the septic fluid is removed by gauze wicks, with or without the aid of glass drains. The head of the bed is elevated twelve or fifteen inches. The patient is prevented from sliding down in the bed by a large pillow placed folded beneath the flexed knees, and upon this the buttocks rest. The pillow is prevented from sliding by a stout bandage passed through at the folded portion and fastened to the bed. This position has also proven valuable for vomiting after etherization, so as to bring the force of gravity to bear in favoring peristalsis. Hourly saline enemas were given, also large doses of strychnine and citrate of caffein in some cases, and in others one-fifth of a grain of calomel every half hour, until two grains had been taken.—*Medical Record*, April 14, 1900.

George R. Southwick, M.D.

ATMOKAUSIS IN THE TREATMENT OF OBSTINATE UTERINE HÆMORRHAGE (Czempin.).—The writer found that complete atresia of the uterine cavity followed the use of live steam in it in a puerperal case, and tried to produce the same result in two cases of uncontrollable hæmorrhage with stump exudates after double ovariosalpingotomy. The results were so good, he tried it in nine cases of climacteric hæmorrhage with equally good results and no evil consequences.—*Centralblatt für Gynäkologie*, No. 2, 1900.

George R. Southwick, M.D.

APPENDICITIS SIMULATED BY HYDROSALPINX WITH TWISTED PEDICLE.—Baldwin, Columbus, Ohio, reports the following rare case. On Sept. 21, 1899, was called in consultation. Patient was well nourished, and had apparently enjoyed excellent health. Had been married twenty three years. Had never been pregnant except once, about two years ago, when she had a miscarriage at the fifth month as the result of a fall. She had been sick twenty-four hours, and gave the following history: On the evening of September 19 she missed her chair in sitting down, and sat down on the floor. At midnight, about three hours after her fall, she was awakened by intense pain in the abdomen, and, this increasing, she sent for her physician about 2 A. M. She had been vomiting, and, when he saw her, was evidently very sick. He saw her at intervals during the entire day and tried to administer purgatives, but was unable to do so, the vomiting being persistent; but she had not vomited for two hours previous to my seeing her. The pain and tenderness had been in the region of McBurney's point, and her physician's presumptive diagnosis was that of appendicitis.

On personal examination I found the abdominal muscles on the right side

exceedingly rigid, as the result of the underlying tenderness. Vaginal examination was entirely unsatisfactory. Abdomen was somewhat tympanitic, but I could make out a very small mass back of the uterus and to the right. The pulse was 80, the temperature 100°. The diagnosis seemed to rest between trouble with the right tube and appendicitis, with possible involvement of both organs. Her appearance was that of a very sick woman. I advised the continuation of hot applications, with absolute rest and delay until daylight. At 9 A. M. the patient's temperature was 100½°, pulse 95; abdomen still tympanitic; had vomited at 2 A. M., and had been greatly nauseated ever since; no movement from the bowels; no change of local conditions; facial expression worse than at midnight. Her condition was so serious that it was now evident that operative intervention was absolutely imperative.

Examination under chloroform showed a small cystic tumor back of the uterus and to the right. Its character could not be determined. It seemed about as large as a goose-egg. Ectopic pregnancy was considered, but was eliminated by the inflammatory conditions present.

The abdomen was opened in the median line. Some bloody serum welled up into the incision, with recent lymph, showing the beginning of peritonitis. The patient being placed in the Trendelenburg position and the intestines pushed out of the way, a gangrenous cyst was found with a twisted pedicle. The pedicle being untwisted, the cyst was found to be an old hydrosalpinx, into which had occurred a recent hæmorrhage. The cyst was easily removed, the ovary being left, as it seemed entirely normal. The left tube was found bound by adhesions, and also the site of an old hydrosalpinx. The ovary on this side being imbedded in the mass, both it and the tube were removed. The vermiform appendix was found with some difficulty, being bedded in old adhesions and the seat of chronic inflammation.—*American Journal Surg. and Gynec.*, March, 1900.

W. D. Carter, M.D.

AN ABDOMINAL INCISION.—Bouvier, Jeanerette, La., advises the incision described below, and claims for it the following advantages :

1. Impossibility of post-operative hernia.
2. Impossibility of deep-wound infection by ill-fitting or slipping bandages or patient's interference.
3. Special adaptation to and utility for thick abdominal walls, rendering coaptation and perfect union certain in cases where the abdominal walls are rich in adipose tissue.
4. It renders the abdominal walls thinner and more elastic, therefore easier of manipulation through a smaller opening.

Technique.—Prepare the patient in the usual manner. Make a vertical incision through the skin and aponeurosis of the external oblique muscle, one and one-half inch to the left of median line. At each extremity of this incision make another, at right angles, to a point half an inch to the right of the median line; dissect up the intervening skin and aponeurosis, to the limit of the transverse incisions. A cut is now made in the median line through the remaining muscles and peritonæum, which gives an abdominal wall practically the thickness of the internal oblique and transversalis muscles, fascia and peritonæum. In closing the deep wound, if the peritonæum is to be included with the deep muscles, absorbable suture material should be used; if not, silk will give the best results.—*International Journal of Surgery*, March, 1900.

W. D. Carter, M.D.

THE PERMANENT RESULTS OF AN OPERATION FOR MYOPIA.—The writer treats extensively upon the recent procedure of removal of the lens in myopia, which operation shows such brilliant results that there exists hardly an oculist who would oppose it in theory. The vision of the operated myopic patient becomes, as most operators agree, better than it was before the operation, even with the best correction of concave lenses. The author also speaks at length of the causes of the bad results and of the factors which, when not observed, become the cause of these bad results. Goldzieher then speaks of Schnabel's assertion, who is of the opinion that "the myopic patient loses as much in his vision for near as he wins in his vision for distance," and then cites the assertions from Haab, Hess, Hippel, and Sattler, who consider the opinion of Schnabel incorrect. He concludes that the operation serves perfectly its purpose, the advantages of the operation completely overshadowing its dangers, and that the operation is worthy of being further cultivated and completed by oculists."—W. Goldzieher, *Ung. Med. Presse*.

Wm. Spencer, M.D.

PROTARGOL COMPARED WITH NITRATE OF SILVER AS USED IN THE CREDE METHOD.—The author has used 20 per cent. solutions of protargol in one hundred cases of ophthalmia of the new-born, and he concludes that it is a better agent in every sense of the word than nitrate of silver. Kramer observed in one hundred cases of the same affection, where nitrate of silver was used, inflammatory reaction ninety-six times, and more than once this reaction was attended with profuse secretion, which persisted for several days; and in 80 per cent. of the new-born, where protargol was employed, there was either absolutely no secretion or only very slight; and in those cases where there was increased secretion, in 50 per cent. it disappeared after a day, and in only 4 per cent. lasted till the fourth day. Engelmann has never observed inflammatory symptoms attending the use of protargol, while he has had 9 per cent. of the cases affected with conjunctivitis after the use of nitrate of silver. Engelmann concludes that 20 per cent. solutions of protargol possess practically no irritating properties, and that it is always to be preferred to nitrate of silver.—Dr. Engelmann, *Centralblatt für Gynäkologie*, November 9, 1899.

William Spencer, M.D.

SYMPATHETIC OPHTHALMIA FORTY YEARS AFTER THE ORIGINAL INJURY.—Finlay reports such an event in a woman fifty years old, who, when ten years old, had been wounded in the right eye by an arrow. The eye became atrophied, and there was no trouble with it until December, 1896, when she suddenly felt pains in the eye one night, with injection of the stump, apparently without cause. The left eye still remained normal. As the pain and injection of the stump continued, enucleation was proposed, but refused. At the end of March, 1897, the pain increased, and the left eye now showed some foggy and photopsia; the edges of the disc were obscured, the vitreous contained opacities, but the iris remained normal; there was no ciliary injection, and V.=1. Enucleation of the stump was performed in May, 1897, seventeen days after there was exudation at the edge of the iris, and V.= $\frac{3}{4}$.

With all signs of cyclitis, vision sank to $\frac{1}{16}$, but the disease was stopped with the retention of useful eyesight.—*Progresso Medica*.

William Spencer, M.D.

THE EVILS OF OVERWORK IN SCHOOL CHILDREN have claimed the attention of the Swiss officials. In the canton of Luzerne the provision is that no lessons shall be studied at home, and that only moderate tasks be required in the secondary schools. Ten minutes' recess every half-hour are called for, and a week's vacation every six or seven weeks. Attendance at school is not to begin before the age of seven years.—*Ophthalmic Record*.

William Spencer, M.D.

REGENERATION OF THE CRYSTALLINE LENS.—Baas reports a very interesting case of a woman sixty-two years of age, in whose eye a new lens formation was observed. The patient had undergone, twenty-seven years previously, several discission operations for cataract.

These operations had given her good sight. At present there is a certain amount of capsular thickening, which becomes thicker upward and outward, and from this capsule there sprang out a club-shaped projection into the vitreous space. This projection was slightly narrower at its middle and ended in a distinct enlargement or head, which Baas designated as a new lens, and which was not unlike a cyst in appearance. It lay behind the iris, a little more than the depth of the anterior chamber, and with the ophthalmoscope resembled closely the pictures presented by a lens which has been luxated into the vitreous. There were opacities in the vitreous body and liquefaction of the latter, which condition led him to assume that the cause of the cataract in the first instance was a chronic disease of the choroid. He discusses the various works bearing upon the regeneration of the lens in the lower animals, notably those of Coeteau and Leroy d'Etiolle, Millot and Goniu. He suggests the name of leutoma or crystalline tumor for the growth of his case.—Professor K. Baas, of Freiburg, in *B. Münch Med. Wochenschr.*, November 28, 1899.

William Spencer, M.D.

THE USE OF STRONG SUBLIMATE SOLUTIONS IN OPHTHALMIC PRACTICE.—The instillation of a 3 per cent. solution of sublimate in muco-purulent conjunctivitis is very highly recommended. Such a form of conjunctivitis is frequently seen as a result of infection with the Koch-Weeks bacillus, also in the strumous constitution, and in such instances is usually designated eezematous conjunctivitis, or scrofulous conjunctivitis. The same condition is seen after measles and scarlet fever. In all these varieties of the same affection, three or four applications of a 3 per cent. solution of sublimate will often change the entire character of the disease, and convert it into one which is readily curable by other more commonly used remedies. The effect of this agent upon the secretions is remarkable. The purulent character of the secretion soon disappears.

The acute forms of trachoma and follicular conjunctivitis often assume the guise of a muco-purulent conjunctivitis, and in both of these cases sublimate solutions will be found most helpful. It is interesting to note the fact that the solutions used, in acute trachoma and pannus were three times as strong as the solutions used in hand disinfection. The solution is dropped once daily on the upper and lower lids, care being taken not to touch the cornea. The beneficial action is attributed not only to its action as a disinfectant, but also to its astringent and caustic properties.—Dr. Emil Guttmann, *Deutsch Med. Wochenschr.*

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

ALUMINA IN CHRONIC PHARYNGO-LARYNGITIS.—This drug is of service in a relaxed condition of the mucous membranes ; as in the “sore throat” of clergymen. The pharynx is dark red, the uvula elongated. There is hoarseness which is worse of mornings, with a sensation of a splinter in the throat on swallowing. Sanguinaria is distinguished by the extreme dryness of the mucous surfaces. The nostrils become painful and excoriated, with fluent and irritating coryza. There is associated aphonia and a sensation of swelling in the throat, which seems as if it would suffocate the patient.—*Rivista Omiopatica*, No. 2, Anno xlv. (According to Heinicke it is particularly efficacious in chronic nervous states characterized by great weakness and excessive irritability, and more particularly in hysterics and hypochondriacs. It is especially adapted to old people and scrofulous and delicate children who are raised on the bottle. The intestines are inert ; the constipation characteristic. Chronic catarrh of the posterior pharynx, according to G. Sieffert—*Formulaire de Therapeutique Positive*, p. 18, (1899)—is an indication ; there is a dry cough, which is suffocating, with pain in the throat, and which cough is brought about by a tickling in the larynx.

Frank H. Pritchard, M.D.

ARSENICUM IODATUM IN SUBACUTE PARENCHYMATOUS NEPHRITIS.—Dr. Lambrechts was consulted by a robust peasant of 47 years who for several weeks had been suffering from a parenchymatous nephritis, with a great amount of albumin in the urine and oedema of the body and ascites, with a low general condition. His abdomen had been punctured twice, and fluid withdrawn. His vision was so poor that he was unable to recognize anyone ; he was extremely weak, his appetite reduced to nothing, the urine scanty and full of sediment ; there were headache, somnolence and nocturnal delirium. His (old-school) physicians declared all hope to have vanished, and he received the last sacraments. It was then that the writer was consulted. The urine contained an enormous proportion of albumin, eighteen gms. to the litre, urea twelve gms., with numerous fatty and hyaline casts. Canthar. 3c. was prescribed for ten days ; there was a notable aggravation, so that a third paracentesis of the abdomen was necessary. Ars. iodat. 1x, ten cgms. a day, was given. In five days he was better ; he passed somewhat more urine, about half a litre a day ; milk is easily digested. Six days later he passed ten litres per diem, and the oedema considerably decreased, as well as the headache. The remedy was continued for about three months, adding nux, cactus and opium whenever the symptoms of the head, heart or digestive tract required them. At the end of these three months he was in a very satisfactory condition. The oedema had almost entirely disappeared, except that

about the ankles and the eye-lids, his vision had improved, the stools were more regular, while the headache and somnolence had become less pronounced. He was able to sit up for several hours, and to take a few steps in his room. The urine still contained nine gms. of albumin to the litre. Ars. iod. 3x was prescribed, and a little white meat and a few vegetables allowed. Four months still later, on a fine spring day, the patient came to Antwerp in person. He was a tall and vigorous-looking individual. When at his worst he weighed one hundred and forty kgms., while his weight now was ninety-five kgms. On examination he presented a notable hypertrophy of the right ventricle; the heart-sounds were normal, yet somewhat weak. The retina presented an effusion which was retrogressing; the stomach and intestines were greatly distended by gas. He complained especially of difficult digestion and distention after eating. The urine still contained seven gms. of albumin and a few hyaline casts. The same treatment was continued for over two months longer, when he considered himself completely restored to health. He was able to walk for an hour, and to do light work, without fatigue; his appetite was excellent, the stools normal, and his head free from pain or distress. The urine still contained three gms. of albumin. Though the cure is not complete, yet if one recall the desperate condition in which he was taken in hand, it will be seen what an excellent remedy we have in the iodide of arsenic in these cases—diffuse or parenchymatous nephritis tending towards chronicity. The patient was not a drinker; his disease began seemingly as a severe “cold.”—*Journal Belge D'Homœopathie*, No. 5, vol. 6.

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MERCURIUS SOLUBILIS IN TOOTHACHE.—Dr. Goullon in a case of toothache of middle age, who for years had suffered from a heart affection, and who noticed that the gum about a tooth had begun to swell, with pains radiating into the neck and head. There was considerable palpitation of the heart; the pain was aggravated by the warmth of the bed, and on trying to sleep on the sofa he would be seized with chilliness. Immediately after he felt feverish. Merc. solubil. 6x brought about relief in a short time, and no suppuration followed. Mercurius is characterized by toothache more pronouncedly than any other remedy. It is indicated in the toothache of carious teeth; the pains are sticking, tearing or boring, but not limited to their place of origin, for they may irradiate into the ear, other teeth, or throughout the whole side of the face. They are aggravated by the warmth of the bed, by lying down, eating and drinking, but are temporarily alleviated by holding a little cold water in the mouth. The maximum is felt late in the evening till midnight, after which they gradually decrease without wholly disappearing. Warmth locally aggravates, but warm applications to the cheek often relieve. External cold and drafts are especially apt to aggravate. At the same time there is often an inflammatory state of the gums, which are swollen, red and tender, the cervical glands are enlarged, there is increased secretion of saliva, and general fever, with an inclination to sweat, which does not relieve, with anxiety and restlessness which forces one to keep in motion.—*Homœopatisk Tidsskrift*, No. 3, 1900.

Frank H. Pritchard, M.D.

SULPHATE OF CHELIDONINE IN CANCER OF THE STOMACH.—Dr. M. N. Ivanhoff, of Gjatzen, Russia, had under his care a woman of fifty-two years affected with cancer of the stomach. She was profoundly marasmatic, suffered

from violent pains localized in the region of the stomach, vomiting everything that she ate, so that she had to be fed by the rectum. The vomit had the appearance of coffee-grounds; besides, the liver increased in size, and the left lobe presented a protuberance which was very sensitive to pressure. A malignant growth, probably near the pylorus, with metastases in the liver, was diagnosed. The sulphate of chelidonium was given in doses of ten to fifteen cgms. twice a day. The patient improved rapidly, the vomiting which had persisted for three months ceased at the end of twelve days, the sensitiveness of the hepatic growth as well as that of the stomach rapidly decreased, and the appetite returned. The patient was soon able to leave her bed and to take food by the mouth; she gained in flesh and felt quite well. However, the tumor of the liver indicated the persistence of the morbid process.—*Ibidem*.

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TREATMENT OF WARTS.—Dr. Karcher mentions first thuja, which, both internally and externally, of all remedies known, is most useful in warts, but is particularly indicated in those of a cauliflower-like appearance. Other remedies are:

Causticum when the warts tend to bleed slightly, are horny, with a solid base, and are painfully inflamed.

Calcarea carb., warts with a soft base.

Dulcamara, *rhhus* and *causticum* are used in smooth and fleshy warts.

Causticum and *lycopodium* when they are pediculated.

Thuja, if they are conical.

Sepia in red warts, especially those about the mouth.

Sulphur in warts that are accompanied by itching.

Phosphoric acid when they are pointed in form.

Antimonium crudum and *arsenicum* when they are surrounded by ulcerated tissues.

According to the regions which they occupy, the following remedies are indicated—On the chin: calc. carb., dulc., sepia (about the mouth); on the neck: calc. carb., sepia; on the arms: rhhus tox., thuja; on the hands or fingers: dulc., especially on the dorsal surface; rhhus tox., sepia, sulphur, calc. carb., natrum mur. (the palms of the hands); on the plantar surface of the feet: ant. crud. Externally one may use thuja, dulc., rhhus tox., spiritus sulphuris.—*Ibidem*. (I have found a saturated solution of the bichromate of potash an excellent topical application for warts. Kaposi, I believe, first recommended it).

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PETROSELINUM IN THE PAINFUL URINATION OF PROSTATICS.—A case of prostatic hypertrophy, with painful urination which had resisted canth., sulph. and cannabis, was relieved of the pain by petroselinum 3x in a few days, after having persisted for years. The remedy was given every two hours.—*Ibidem*. (*Cantharis*, if employed in the beginning of pleuritis, is often better than the more generally used bryonia.)

INDICATIONS FOR STROPHANTHUS.—In the *Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Bd. xviii., Hft. vi., without giving the source, the following indications for strophanthus are presented: (1) The contractions of the heart are rapid, but weak and irregular; (2) there is a lack of vasomotor

power, if there be increased arterial tension, as in Bright's disease, arteriosclerosis, and atheroma of old age; (3) in all cases where diuresis may be obtained by increased blood-pressure, from increase of heart-power, strophanthus will bring it about; (4) when a rapid action is necessary it is indicated, as it is quick in action and excreted regularly; (5) the absence of digestive disturbances (?) after a therapeutic dose and the organism becoming accustomed to the remedy renders it serviceable in cases where a heart- tonic must be employed for a long time. The states in which it may fall are:

(1) Advanced degeneration of the myocardium; (2) extreme mechanical hindrance to circulation from insufficiency or stenosis of the valves; (3) a combination of these states.

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TREATMENT OF CONSTIPATION.—At a recent meeting of the French Homœopathic Society, Dr. Boyer recommended alumina 6x as a very serviceable remedy in the constipation of persons who have a very obstinate form, possibly a movement four or five times every month. The fæces are like sheep's dung, and are covered with mucus. The patients are confused in mind, and feel indisposed at the least mental excitement, while as to the abdomen, they complain of nothing. It therefore is indicated in sedentary individuals; it may be alternated with plumbum or opium.

Dr. Marc Jousset praised collinsonia 1x trit., one dose before retiring, and found it useful in the associated constipation of pregnancy and uterine affections. Children suffering from constipation often have very voluminous passages; here opium 3x trit. is of service. If the stool be scanty, lycopodium (30x). The complicating constipation of uterine affections may be relieved by magnesia carbonica or muriatica, though sepia in a woman who had not had a stool for years, unaided, did good service; if the uterus be displaced, the remedy is the better indicated. Æsculus is often a good general remedy, though the indications are vague. Dr. Tessier in obstinate cases has had good results from natr. mur. 6x. Æsculus is a useful remedy, but it must be used in the tincture or lower dilutions. In rebellious cases, calomel 2x will do good service. In children, this remedy acts well. Dr. M. Jousset would employ merc. dulcis 1x instead of higher triturations.—*Allgemeine Homœopathische Zeitung*, Nos. 11-12, 1900.—(Merc. dulcis 1x is a very handy and palatable remedy in constipated children. It is wholly without taste.)

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TARAXACUM IN DIABETES.—Hahnemann was in the habit of employing the juice of this plant as a remedy in diabetes. It is a drug which in earlier years was much employed in affections of the liver and pancreas. As of late the connection between diabetes mellitus and lesions of the pancreas has been pointed out, it might be well to remember this old remedy in treating diabetes.

IODIUM IN TYPHOID FEVER.—Dr. Leon Simon asserts that this remedy is wholly homœopathic to typhoid fever in full development. According to Hahnemann and its pathogenesis it is homœopathic to typhoid based both on its anatomico-pathological findings and the functional disturbances. It is indicated in typhoid fever of moderate intensity of the abdominal and adynamic form though it may also be useful in the pulmonary complications of the disease; but it is not to be advised in the cerebral, ataxic or hæmorrhagic varieties.—*Journal Belge D'Homœopathie*, No. 5, 1900.

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THE HAHNEMANNIAN MONTHLY.

JUNE, 1900.

SOME EXPERIENCES AND SUGGESTIONS IN CONNECTION WITH URINARY ANALYSIS.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

(Read before the Saturday Night Club of Microscopists, Philadelphia, April 21, 1900.)

SEVERAL years ago I became interested in the investigation of the urine. In the pursuance of my studies in this direction I have had some instructive experiences, and I have learned how to do some things in my own way. Books give very attractive directions which are (apparently) easy to follow until one makes the attempt; and then one all too often discovers how very sadly he lacks the technique of the gifted author!

What I want to do to-night is to try, in some degree, to popularize the practice of Urinary Analysis—and the way to popularize it is to make it easy; *i.e.*, to simplify it and make it easy to understand, easy to work out, and to show easy technique, always looking to the end that our results shall be prompt and reliable.

Let us begin with urea. Here is a subject of the first importance—one that every physician should be thoroughly conversant with, both in theory and practice. Recognizing the fact that *in urea lies the danger-line*, he should be able to determine the absolute status of the amount of urea in every case, as upon this the prognosis of his case so greatly—or almost entirely—depends. Am I speaking too strongly, think you, when I say, *as the urea, so the prognosis*? If you do think so,

just make a careful series of experiments and observations for yourselves, and then tell me how much or how little importance you think should be placed upon the amount of urea present—not in one single examination, mind you, because such a result may, and often does, signify but little. To be of real value, an examination of the urea should be made not less than three or four times a week, and always under these three conditions:

1. The urine must be saved for 24 continuous hours;
2. The amount of urine passed in 24 hours must be known and considered;
3. The state and food of the patient must be known, *i.e.*, (a) whether the patient was at rest, or indulging in moderate or violent exercise; (b) whether during the 24 hours he ate much “urea-producing” food.

We are all familiar with the Doremus ureameter and the hypobromite solution. Under normal conditions there should be from 25 to 30 grammes of urea in 24 hours. To obtain the correct estimate of urea we must

1. Ascertain the number of ounces of urine passed in 24 consecutive hours;
2. Multiply the number of ounces by 30 (this equals number c.c. because, roughly estimated, each ounce contains 30 c.c.);
3. Multiply the product by the reading of the ureameter: *e.g.*,

Suppose in 24 hours there are 50 ounces of urine;	then amount of urine
in 24 hours	50 ounces.
Multiply by	30 because there are (about)
	— 30 c.c. in each ounce of
	urine.
	1500 = total amount of c.c. in
	24 hours.

Now multiply by the reading of the	
ureameter, which we will suppose	
to be	0.02
	—

The result gives total number of grms.	
of urea in 24 hours	30.00 = 30 grammes, which is
	about normal.

To familiarize ourselves with this method let us work out another result, this time in fractions:

Amount of urine voided in 24 hours, 39 ounces. Multiply

by 30 = 1170 c.c. in 24 hours. Multiply by reading of the ureameter, which we will suppose to be

$$\begin{array}{r} 0.01 \frac{7}{10} \\ \hline 11.70 \\ 8.19 \\ \hline 19.89 \end{array}$$

grammes of urea—a marked deficiency.

The following simple and fairly correct method of roughly estimating the amount of urea in a very short time is worth knowing, as we may at any time need to use it. Imagine one of us, or a doctor in the country, wanting to test for urea but finds his bromine is all out, or his stock of caustic soda is exhausted. Then it is well to proceed as follows: Having a mixed specimen of 24 consecutive hours, take two samples, one of 6 c.c., the other of 12 c.c., and place them in watch glasses. To the 6 c.c. add 2 c.c. (*i.e.*, $\frac{1}{3}$) of nitric acid C.P.; if immediately or very soon the typical nitrate of urea crystals appear, the proportion of urea is in excess. Slowly, over a gentle heat, evaporate the other sample to about one-half; allow it to cool, then add 2 c.c. nitric acid C.P.; if the characteristic nitrate of urea crystals do not form within a few minutes, the amount of urea is below normal. *The accuracy of this test, like all other tests in urinary analysis, depends upon knowing the amount of urine passed in 24 hours.* If instead of three pints of urine the patient passed only half as much, then to the first sample of urine (*i.e.*, 6 c.c.) add 6 c.c. of water (after which proceed as directed above). The second sample, 12 c.c., should be used without evaporation. Observe the proportion throughout. If only two pints of urine are passed, $\frac{2}{3}$ normal quantity, add enough water to supply the missing $\frac{1}{3}$ and then apply the test. In the second part of the test evaporate only $\frac{1}{3}$, etc., etc.

As microscopists let us now consider how to obtain a fruitful sample of urine for satisfactory microscopic examination. I have found by my own work that the hinge upon which swings open the door to success is, SEDIMENT! Several times I have taken a perfectly clear urine soon after it was brought to me, have filled my centrifuge tubes, turned the crank, placed a drop on the slide, peered through my microscope, and—found nothing. *But*, I have learned that by allow-

ing a clear urine to stand for several hours in a cool place, 24 hours if necessary, a faint cloud (mucus from the genito-urinary canal) is always seen near the bottom of the bottle of urine; this cloud has been uniformly diffused through the urine, and while slowly sinking has acted as a drag-net to draw down whatever casts or renal débris there may be in the sample. Now very carefully pour, or syphon, off the urine above the cloud (which oftentimes is very thin and light), then place in the centrifuge and rotate earnestly a portion of the cloudy urine. Having sedimented, the point of the pipette should be placed *just over* (not in) the part of the deposit which is to be examined—and only a few drops need be admitted; then allow the urine to drop slowly from the point of the pipette until the sediment itself appears, when a drop (of the sediment) is placed on a slide and covered with a cover-glass. By the above procedure with the sediment, casts may be discovered which otherwise would have escaped detection. Indeed the value of the sediment, acting as before stated in the manner of a “drag-net,” is so great that I have often thought of using an artificial sediment which would precipitate quickly and would act in the very few, if any, urines which even after 24 hours do not have a sediment.

To avoid injury to the delicate casts, a bottle of urine for examination should be completely filled and needless agitation of the bottle must be avoided.

A fairly good way to “catch some good finds” is to make a cone of filter paper, fill it with urine, filter; when very nearly all has passed through, a drop of the remaining urine can be placed upon a slide for examination.

Next we will briefly consider the fascinating, quick, easy micro-chemical reactions—and just here is where, in the not distant future, a great reformation in Urinary Analysis will occur. Let me explain what I mean. Night after night I have taken up most excellent works on Urinary Analysis and have studied as hard at the plates of crystalline deposits as any school-boy, trying to memorize the different appearances of the different crystals and the different appearances of the (chemically) same crystals—many of them being of the same nature but of different shape as calcium oxalate; the widely various forms of uric acid, etc., and trying to differentiate the several

forms of amorphous earthy phosphates, amorphous urates, etc. This is what we have all done in the past. But the dark days of dreary drudgery to "*Eye Memory*" are numbered and a bright light has dawned showing the way to better things, for it is no longer necessary to drill the eye to memorize the innumerable shapes assumed by crystalline deposit. The knowledge is now arrived at, *cito et jucundo*, by micro-chemical reaction. Suppose that, having centrifuged a sample of urine, and having placed a drop under the microscope, you find a large field of all sorts of shapes; you want to ascertain what chemical properties those shapes represent. You can do this, by chemical reaction, in one of two ways:

1. Place a large drop of urine upon a slide, and over it place a small cover-glass; of course a great deal of urine will run out from under the edges of the glass. You can then use your re-agent in direct conjunction with the excess of urine. Or,

2. Take a small drop of urine and place it upon a slide; next take a small drop of re-agent and place it near to, but not touching, the urine; then take a large cover-glass, lay it gently over the two drops. The fluids will gradually mix, and the re-agent will proclaim its diagnosis of the crystal while you look through the peep-hole of your microscope.

The exact detail is as follows:

1. Test the reaction of the urine. If acid, your crystalline sediment is likely to be sodium urate, uric acid, leucin, tyrosin, calcium oxalate. If alkaline, you can reasonably consider the crystalline sediment to be phosphates, calcium carbonate, ammonium urate.

2. Procure as re-agents* dilute samples of acetic acid, hydrochloric acid, sulphuric acid, liquor potassa.

To crystalline sediment upon a slide add liquor potassa, when the *urates* and *uric acid* will be promptly dissolved; so too, although less promptly, will *cystine*. Sometimes a modified form of uric acid closely resembles cystine. Add hydrochloric acid, which dissolves cystine but leaves uric acid unaffected. (The phosphates and oxalates will be unaffected.)

* In chemistry, "dilute" means the U. S. P. dilute strength. Thus *Acetic acid* U. S. P. dilute = 6 per cent. of the acid to 94 per cent. water; *Hydrochloric acid* U. S. P. dilute = 10 per cent.; *Sulphuric acid* U. S. P. dilute = 10 per cent. *Liquor potassa* U. S. P. dilute = 1 part of liq. pot. to 20 parts of water. *Liquor potassa* and caustic potash are synonymous terms.

The *phosphates* are dissolved by a slightly diluted glacial acetic acid, with *no* evolution of gas.

The *carbonates* are dissolved by a slightly diluted glacial acetic acid, with evolution of carbonic acid gas.

Calcium oxalates are quickly soluble in strong nitric acid and in strong (concentrated) hydrochloric acid.

Calcium carbonate quickly dissolves, with *effervescence*, on adding a drop of any dilute mineral acid.

Calcium sulphate insoluble in ammonia, acetic and sulphuric acids; is *slightly* soluble in nitric or hydrochloric acid.

Leucin, Tyrosin, Xanthin, Cystin, Uric acid are *insoluble* in hydrochloric acid.

The beauty of micro-chemistry, however, is that it is as diagnostic of casts as of crystals! How often we all have studied an object, through our microscope, and have wondered, "Is this a hyaline cast or not?" "Is that a fragment of a granular cast?" The time has come when we can answer these questions. Rieder states (p. 63) that genuine "hyaline" casts are soluble in acetic acid. In my opinion a cast is a cast—or, to express it in other words, a "hyaline" cast is an empty cast; while a so-called blood-cast is a cast loaded with blood-corpuscles (showing a cortical renal hæmorrhage); a granular cast is a cast loaded with coarse or fine granular débris, etc. So if the object looked at is a cast, it is soluble in acetic acid.

Rieder draws particular attention to the similitude of cylindroids and true casts. He asserts that "cylindroids are found in the majority of normal and pathological urines;" "they may be found along with genuine casts in nephritis;" "those cylindroids which . . . have been termed urethral threads are of special importance;" "cylindroids, like true casts, may be covered with deposits of amorphous granules. . . . In such cases they may be mistaken for hyaline or granular casts."

Briefly stated, the distinguishing features between cylindroids and true casts are: 1. The shape. A cast is practically uniform in shape; cylindroids have a very variable diameter. 2. Cylindroids are usually of great length, "often extending over several microscopic fields." 3. Apply acetic acid. A true cast is dissolved. A cylindroid gives the mucin reaction (*i.e.*, the production of a coarsely granular turbidity).

A strong alkali will dissolve true casts; *but*, it also dissolves

cylindroids. Acetic acid dissolves casts, and does not dissolve cylindroids—it merely produces with them the mucin reaction referred to above. Hence the value of acetic acid as a diagnostic agent.

It is said that muci-carmin, which stains all mucous substances a characteristic red color, is a still more positive means of differentiation. It does not seem to me that micro-chemistry is largely practiced, even though it offers such happy results. I suggest that this club pay particular attention to it this summer and report results in the autumn.

You can easily clean the tubes of your centrifuge when they become dirty or cloudy—or when sediment adheres which will not readily wash out—in one of these ways: 1. Rinse the tubes two or three times with liquor potassa, allowing the liq. pot. to remain in the tubes a few minutes; or, 2. Rinse them, as directed above, with sulphuric acid.

It has been a matter of surprise to me, the last few years, to observe the comparatively large number of people who are walking about *in apparently fair health*, but whose urine shows more or less albumin *and* casts, both hyaline and granular.

It has frequently been stated that the presence of hyaline casts has no clinical weight. It has been my observation that when there are hyaline casts, and at the same time the urine shows albumin, there exists a pathological state which needs medical attention.

Of the dangerous nature of some of the chemicals necessary in urinary analysis a few words are useful. In handling bromine (when making the hypobromite solution) care must be taken to keep the bottle away from heat—or *a violent explosion is apt to occur*, violent enough, even, to tear off one's hand. If the glass stopper in the bromine bottle sticks, do not try to loosen it by running hot water upon it. Do not hold the neck of the bottle in the flame to loosen it, either. Send the bottle to a chemist to have the stopper removed.

Picric acid is frequently used in tests for albumin and sugar. Beware how you apply heat to any of the picric acid solutions, as it may explode with tremendous violence.

Hydrochloric acid has a particular action on the respiratory tract when inhaled, the fumes causing serious interference with respiration, dyspnoea, stridulous breathing and loss of articulation.

Potassium hydrate=caustic potash=potassa U.S.=potassa caustic, British=potassa fusa=potassa alba. In solution this should be protected from air because it rapidly absorbs carbonic anhydride, forming potassa carbonate, which does not have the same chemical reaction.

Potassium ferrocyanide is, of course, known as one of the poisons.

I have dwelt above upon the necessity of taking a specimen from the 24 hours' urine. I know that it is often hard to obtain a 24-hour specimen—therefore every physician must be all the more requiring in his demands to obtain such a sample. Tell your patients—male or female—to use one chamber for the reception of all their urine during the 24 hours, and if they have occasion to defecate they must carry a tin cup with them, hold it up close to their person, and urinate in the tin cup but defecate in the cloaca. A true physician will find the ways and means for making known his wants, and he will be pardoned by his patients for expressing his requirements *in plain terms*.

And now here is a word of caution to physicians. Whenever any one of you sends a sample of urine for examination, always state whether the specimen is a single passage or one of 24 hours' passing—and if the latter, *be sure to state the amount of urine passed in 24 hours*.

Several times I have had this experience. A bottle is handed in at my front door with a little note which reads: "Dear doctor, please examine this urine and report results to yours truly —." These are the only data given. I am not told whether the owner of the urine is a male or a female, child or adult, married or single; whether the specimen is a single passage or one of 24 hours; whether it is a *he*, who is a member of his college football eleven, loaded with nitrogenous food; or whether it is a *she*, who, deep in the throes of neurasthenia, lies stretched upon a bed of real or fancied anguish, eating nothing but dainty tidbits.

Physicians should always give the examiner all the data about the urine, and of the patient who passes it, that they possibly can.

ASAFCETIDA IN HYSTERIA.—Much trouble about the œsophagus; sensation of pressure, or as if a body or lump were ascending in the œsophagus, obliging frequent deglutition to keep it down; soreness in the œsophagus, preceded by burning.

THE UNIVERSALITY OF THE LAW OF SIMILARS.

BY CHAS. S. MACK, M.D., LA PORTE, INDIANA.

I APPREHEND that not all old-school critics are merely captious in finding fault with the homœopath for insisting that the law of similars is universal, while his practice embraces not only homœopathy, but all else that is good in medicine. I doubt not that many, if not all, of our old-school critics have utterly failed to understand wherein lies the universality of the law. Some of them seem to think that the law of similars, to be universal, would have to be the only law medicine. This notion is entirely incorrect. If the law of similars *were* the only law in medicine, that fact would not at all render it universal; for medicine is not the universe. The universality of the law lies in the fact that this law obtains throughout the universe, which includes the realm of thinking and the realm of willing no less than the realm of drug action. This claim of universality might be established not only for the law of similars, but for every law in medicine. Indeed, universality is an attribute of every law of nature. In connection with this remark let me recall to the reader's mind Henry Drummond's book "Natural Law in the Spiritual World."

While in the realm of thinking and in that of willing, as well as in that of medicine, there are laws other than *similia similibus curantur*, it is only through the instrumentality of a similar that there can be effected in the realm of thought, in the realm of will or in the realm of medicine the particular cure of which *similia similibus curantur* is the law. That particular cure is an immediate transformation from abnormal to normal in vital processes and in their effects.* Dealing immediately with proximate causes of disease, or with that in one's environment which, as example or incentive, may prove a proximate cause of false thought or of wrong desire, is, in its place, a grand good thing; but it will never effect (whether in body, in thought or

* The word *immediate* in this definition has no reference to time. It simply means that, to effect this particular cure, a drug must be dynamic, and that it produces no abnormal effect mediate to its curative effect.

in will) the particular cure of which *similia similibus curantur* is the law. Nor will any of the laws under which we use dynamic dissimilars guide us to what will effect in body, mind or heart the particular cure of which *similia similibus curantur* is the law. What I would at present dwell upon, endeavoring to make clear, is that similars are instrumental in effecting, in the realm of thinking and in the realm of willing, no less than in the realm of drug action, the particular cure of which *similia similibus curantur* is the law.

If you seek the immediate* correction of a man's false ideas upon any subject whatever, one thing indispensable is that you bring to his attention, for rejection, the error which he has been holding. There is no possibility of his accepting the truth before he rejects his error, for truth and error upon any given point can no more coexist in one's mind than health and disease can coexist at one point, or than two physical objects can occupy the same place at the same time. The likeness which you present of the error you would have one reject is a curative similar.

With drug similars you point out to vital force various details of disease which you would have it reject; you point to one detail, then to another, as, with various remedies, you touch at this point and at that, until vital force, having loosened its hold upon disease at various points successively, at last altogether rejects it, health takes its place, and your patient is cured. Precisely analogous to this is the immediate transformation from false to true which you effect in a man by holding up to him the likeness of an error which you would have him reject. You show him, now at this point, now at that, what you would have him reject. Little by little he loosens his hold upon his false idea, and finally he rejects it altogether. The false once rejected, room is afforded for what is true. A homœopathic drug is not in itself health-bearing, nor is the likeness of an error truth-bearing. The true thought supplied in the place of rejected error has its analogue in the wholesome food, drink and air which are supplied to a patient.

Cure by a homœopathic remedy has its analogue, then, in that correction of ideas which we bring about by pointing out

* See foregoing footnote as to the meaning of the word *immediate* in definition of the particular cure of which *similia similibus curantur* is the law.

errors and inciting to abandonment of them. These analogues really are effects under one and the same law—one an effect in the body, the other an effect in the mind. *Similia similibus curantur* is just as much a law of cure from intellectual error as it is a law of cure from bodily disease. Not only so, but it is a law in the field of ethics or morals. One could never be radically freed from anything immoral or disagreeable in his character if he were not made acquainted with its nature. One means to such acquaintance is observation of like immorality or disagreeableness in others. That which, in another, is like my own fault is a similar which will prove curative, if I heed its warning. One of the great uses of the drama or of the novel is to show up to us our faults.

“O wad some power the giftie gie us
To see oursel as others see us!
It wad frae monie a blunder free us,
And foolish notion.”

In the field of ethics or morals, and in the field of thought, no less than in the field of medicine, likes show up likes for the purpose of cure. Irresponsiveness to a truly homœopathic medicine finds its analogue in the irresponsiveness of him who refuses to recognize his error of head or of heart when it is pointed out to him; you cannot, with a similar, *force* this cure upon body, mind or heart.

I can but think that this broader view of homœopathy—this view that the law of similars obtains not only in medicine but in other fields—indeed throughout the universe—is likely to be presented in the future more frequently than it has been in the past, and is destined to greatly help the cause of truth.

SOME EARLY SYMPTOMS OF THORACIC ANEURISM.—Dr. A. Symons Eccles noticed in four cases of thoracic aneurism that the intelligent patients stated that many years before their disease had been diagnosed they had suffered from pains in the left and more frequently in the right arm, which would become worse after exertion. At the same time they would experience a feeling of weakness and giddiness on bending the head backwards, as well as an indefinite sensation of anxiety which, for example, in one, a physician, hindered him from riding in a buggy, and in another prevented him from travelling in a railway car. All of these symptoms were noticed at a time when neither the patients nor their physicians had thought of an aneurism.—*Muenchener Medicinische Wochenschrift*, No. 13, 1900.

Frank H. Pritchard, M.D.

THE EARLY DIAGNOSTIC SYMPTOMS OF LOCOMOTOR ATAXIA.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., April 11, 1900.)

It is rarely difficult to diagnose locomotor ataxia when the disease is so well developed that all the stigmata have come to the surface, or when the disease is so far advanced that the patient is beyond all possibility of even temporary help. It is, however, difficult to recognize it in its very early stages. Like phthisis, or any other chronic disease of the human organism of slow onset, it has certain peculiar individual symptoms that give us the right to suspect its presence or anticipate its development in the future.

When it is understood that locomotor ataxia is a disease usually of very slow development, and that it may exist in the system for a period of from ten to thirty years, the importance of its early recognition will be apparent, not only for the purpose of relieving the immediate symptoms and the prolonging of life, but that we may search the means of cure of a disease that is to-day incurable.

Certainly, none of the symptoms noted in this paper as the early symptoms of locomotor ataxia is constant in every case at its onset, but more or less of them will appear in every case, at its beginning, that should make the attending physician sufficiently suspicious to press his examination to the last degree. The classical symptoms, as you all know, are the lightning pains, the absence of the patella tendon reflex, the Argyll-Robertson pupil, diplopia, the gastro-intestinal crises, the bladder and sexual crises, the ataxic gait, and, lastly, the bone changes, which usually develop late. Any of these symptoms may be the first to appear, except the last. We have the record of a case in the Hahnemann Hospital Dispensary in which the pains began in 1867, and have continued with more or less severity ever since. The patient was not compelled to leave his employment on account of further development of the disease until 1892. But these early pains are not always lightning-like. They are often described by the patients as a sensation as if metal clamps were placed

around the leg and gradually tightened, with a sense of soreness between the intervals of pain. Again, they are described in the very early stages as a momentary stinging in the skin that makes the patient start. That form of the pain, known as the girdle-pain, which attacks and surrounds the trunk of the body like a girdle, appears frequently in its early form as a soreness and cramp in the muscles of the back, particularly under the shoulder-blades. While it is not common, occasionally we find cases in which sexual impotence is the one symptom giving the patient any inconvenience for a period of many years.

Patients will come to you complaining that they have difficulty in passing the water, complaining of nothing else. An examination of the genito-urinary organs reveals no abnormalities. Upon questioning, they will say that, perhaps, years ago they noticed that they were compelled to press more or less forcibly upon the bladder to completely empty it. Of the symptoms of the eyes, we find, first of all, the Argyll-Robertson pupil; in this condition the pupils respond normally to accommodation, but not to light. But there are peculiarities about this symptom. I have a patient who has so many of the truly classical symptoms of locomotor ataxia that there cannot be the slightest doubt of the correctness of the diagnosis, and yet, upon examining once a week, I have seen the pupils for a period of six weeks absolutely unresponsive to the strongest and most sudden light-changes, when suddenly, for a certain time, the pupils would react to light almost if not quite normally. You ask me how I account for this. On the ground that in the early attack upon any of the centres the symptoms are not constant, but recur at intervals and with periods of relief.

Sometimes very early in the disease diplopia occurs, and the patient may present himself to his physician, frightened because he has seen double. This symptom also is not constant, but may disappear and reappear many times in the course of the disease. While optic nerve atrophy occurs, it rarely, if ever, appears very early.

A pin-point pupil should suggest immediately the possibility of posterior spinal sclerosis.

Of the head and face, no symptoms occur sufficiently early to be classed among the early diagnostic symptoms.

While in many locomotor ataxies we find excellent teeth, in a certain percentage we will find a gradual breaking down of the teeth, which seems impossible to control, and the dentists will say that in spite of the greatest care the filling comes out and the bone simply crumbles away, apparently without cause. This symptom later on, as the disease develops itself, advances to the alveolar processes of the maxillary bone, and the patients frequently pick the teeth out with their own fingers. The decaying or loose teeth, then, should be suggestive of future danger. The early symptoms of the gastric crisis are usually dyspepsia, puffing in the stomach and general abdomen after eating, raising of a sour or bitter gas, with bad taste in the mouth. As the disease progresses the puffing of the abdomen becomes, at times, almost unbearable. These pains, sometimes slight, again most intense, occur associated with more or less nausea, and at times severe attacks of vomiting. One of my patients tells me that for many years he was troubled with these symptoms, in spite of the fact that he took the best care of his digestive organs, and that no one seemed to be able to relieve him. This same patient tells me that long before the appearance of the digestive disturbances he used to experience difficulty in swallowing. At times the food, and even the saliva, would slip into the throat before he was ready to swallow it, and choke him. That he was troubled with a peculiar momentary spasmodic cough that would make it almost impossible to draw the breath. Fortunately this symptom has abated since the disease has developed in other directions.

In regard to the bowel crisis, permit me to state a case, which is as follows:

Mr. C., aged 59 years; married; by occupation dealer in farming utensils; gives no specific history, and with exception of the presence of tabes, impossible to find any signs of it. Father of four children, all living and well. Two sons very large, fine physique; daughters equally well-developed. Wife never had any miscarriages. Presents to-day these classical symptoms: Argyll-Robertson pupils, loss of patella tendon reflex, ataxic gait, lightning and girdle-pains, difficult urination, gastric and bowel crises. This will establish well the diagnosis as that of locomotor ataxia. On signaling each individual symptom and learning the time of its origin, the bowel crisis

was pre-eminently the first. At eighteen years of age he began to have attacks of profuse watery diarrhœa, in which, as he says, "The stools would squirt from his bowels like water from a hose." The attacks would come on at first at long intervals, of a duration of from two or three days to as many weeks, and followed by no sensation of weakness, not influenced by anything he did or ate. Finally they became more frequent and of longer duration, during this whole period being of exactly the same character, until to-day, if they appear, they last from one week to three months.

This appears to me to be the typical bowel crisis, from the very first diarrhœic attack that this patient had forty years ago. Certainly it is the type of the tabetic diarrhœa. If this is true, it gives us an idea how long this disease can remain comparatively latent in the human system before it breaks forth into active degeneration. Wherever we find the tabetic diarrhœa, whether in the early or late stages, it is of this character, and it obstinately defies all treatment, homœopathic or other. In the meantime this patient has had other attacks of diarrhœa, such as come to the most of us during the summer time, but he quickly defines the difference between them and denies that they are the same in any particular. These attacks do, at times, make the patient weak; but they are usually painless or associated with very little pain. The pain in the stomach and bowels may be coincident with, but are independent of, the attacks of diarrhœa, and are a part of the girdle-pain. Our rectal specialists tell us of a peculiar patulous condition of the rectal mucous membrane to digital touch that makes it possible for him to diagnose the presence of locomotor ataxia as early as it can be recognized by any other means.

And right here allow me to speak of another symptom that I have found in connection with these parts, a peculiar itching in the sulcus ani, just outside of the anal ring. Almost every tabetic patient develops this symptom sooner or later, and many of them give the history of its existence years before they suffer any inconvenience in any other way. It is possible that this symptom is coexistent with the rectal changes. They suffer much with its annoyance, and are likely to speak of it sooner or later. In watching the course of these cases I have found that about 15 per cent. of male tabetics give a history of

most offensive sweat of the perinæum and scrotum, requiring that they take especial care of these parts lest they become noticeably offensive. Whether 15 per cent. of all the male sex have this peculiar symptom when in a presumably normal condition or not I do not know, but I do know it exists in tabetics, and they give a distinct history of the period of its onset long years before other signs of the disease appear.

We pass on now to the symptoms of the extremities. Frequently among the earliest of these is the numbness that appears in the hands and forearms. This symptom appears in rheumatism, in neuritis, etc., but it should never be carelessly passed over, for it sometimes has a much deeper significance. Patients come early who complain of this, because they usually fear that it is a forerunner of a "stroke," as they say. The careful observer will immediately find that the numbness extends from the elbow down the outer aspect of the forearm, and involves the ring and little fingers. When this symptom is met with, the patient should be carefully searched for further signs of spinal degeneration. This same peculiar numbness occurs very early in the feet at times, and the patient complains of a sensation as though walking on cotton. There are other spots of numbness over the surface of the body, but these, while not rare, require an expert to find, and are, therefore, not serviceable to the general practitioner for the purpose of diagnosis.

A certain class of these cases complain of having had for years corns and callouses on their feet. In fact, we can frequently raise the outer scale of a corn on the bottom of the foot of a tabetic, and a small amount of fluid will be discharged. A further investigation exposes the existence of a small round hole under the surface that seems to burrow with perfectly smooth walls down into the fleshy part of the foot. These should be carefully guarded, for in tabetics they are the beginning of the round perforating ulcers.

One of the most important points in the early recognition of the disease is to know how the ataxic gait approaches. Finely built robust men will tell you that on coming down stairs they feel a peculiar weakness of the knees that compels them to be careful, lest their legs give way under them. This symptom is very common in the early onset of the disease, and for a long period they suffer no other inconvenience. Again, on attempt-

ing to wash the face in the morning, as they bend over the wash-bowl, dashing the water over the face, they are compelled to grasp the wash-stand to maintain their balance. Later on, when we bid them put their feet together and close their eyes, we find a gentle swaying of the body, static ataxia. This announces that the ataxic stage has begun. This may continue months or years before the patients develop the disordered gait.

Now comes the symptom known as the absence of the patella tendon reflex. This is a very important symptom from the standpoint of diagnosis. The sclerotic condition of the posterior columns of the spinal cord in a vast majority of cases attacks the lower segment of the cord first, and, as the sensory nerve-roots enter the spinal cord, they traverse the posterior white columns before entering the gray matter to form their connection with the anterior motor cells. It will then be plainly seen why, at the very beginning of the hardening process in the posterior columns, the sensory connection with the anterior motor cells is closed off and the patella tendon reflex is lost. This symptom *may* be the first to show itself. But it must not be forgotten that it may not develop until the disease is well established. Thus, I have tried to detail as briefly and plainly as possible the important diagnostic symptoms of locomotor ataxia in its early stages. I do not claim to have given them all, but I have tried to give those that have sufficient importance on the early stages of the disease to place the physician on his guard, and prepare him to anticipate further symptoms, that he may protect the patient, if possible, from a rapid onset of the disease. I have not gone into the symptoms demonstrating the more advanced stages, for with these this paper has nothing to do, it being only on the earliest diagnostic symptoms. If I have made clear to you some of the points by which you can recognize this constantly increasing malady in time to be of service to your patient, then I feel that I have accomplished my end, and am content.

VERBASCUM THAPSUS is a very useful remedy in catarrhal affections. In distressing and irritating cough, accompanied by hoarseness, it acts promptly. In acute cases, 1 to 2 drops of the tincture every hour, with local application to the chest of the oil of mullein, will act well.—*Zeitschrift des Berliner Vereines Homöopathischer Aertzte*, Bd. xviii., Hft. vi., 1900.

MERCURIUS IN THERAPEUTICS.

BY JOHN HUTCHINSON, M.D., NEW YORK.

THE alchemists gave the name Mercury to all volatile substances, only one of which has retained it. And this one has brought down through the ages not merely its own power to cure human ailments, but, as well, much of the story of medicine itself. For hydrargyrum, or mercury, whose physical properties, chemical possibilities and value in the arts are of magnificent importance, stands as one of the most interesting and most suggestive of therapeutic agents in the domain of medicine. Its broad application, both primitive and modern, evolves a panorama of medical history.

By methods of fumigation and inunction the ancients appropriated the element for disease, and something of its real therapeutic value has been known for centuries. It may be safe to say that no other single medicinal substance has received more attention since its discovery.

The Greeks and Romans were presumably unacquainted with the liquid metal in any therapeutic sphere until after its use by the Arabian physicians who applied it to skin affections. That Avicenna and Rhazes prescribed mercury for eczema, psoriasis, herpes, ulcers, small-pox and general swelling we may not doubt, even if their diagnosis and methods differed from those of the nineteenth century.

Paracelsus was the first European physician to use mercury internally. Aristotle, about B. C. 370, was among the earliest to mention the metal, calling it "fluid silver." It is difficult, if not impossible, to determine accurately when the Chinese began to employ mercury, though they used it for syphilis at a remote period. Hence the appropriateness of this much-abused remedy to an ancient and dishonorable scourge has at least the sanction of antiquity.

The English have used mercury since the thirteenth century. "Blue pill" for disordered liver has long been a watchword, coupled, in some professional circles, with the injunction "to be taken till the gums are touched." Within sixty years, while

bleeding was called "the left arm," mercury received the name "the right arm of medicine." Lavish has been and is yet its use for syphilis, though "the firmest believers in the efficacy of mercury in syphilis agree that quantities sufficient to produce salivation are pernicious."

This passing glance toward the earlier history of mercury in medicine leads to a brief speculation as to the basis of its therapeutic application; and it is not easy to refrain from some conjecture as to the influence of primitive ideas upon later and possibly more correct practice. How much of comparatively recent abuse is attributable to traditional methods and prescriptions may never be known. Certain it is, however, that enormous mistakes in the application of an important drug have resulted in much-needed reform, following also the investigations and study consequent upon instances of disastrous constitutional poisoning. These latter examples may have been in the mind of the Edinburgh physician when he exclaimed, "That dread triumvirate, mercury, pox and scrofula!" So, notwithstanding the broad sphere of mercury, we are forced to the conclusion that we have scores of remedies better suited to the conditions for which, in many instances, it was formerly prescribed. During the past one hundred years or more the various forms of mercury have been administered in different ways and according to different principles, each more or less dominant in its turn. Owing to this fact we have derived much of our knowledge of the range and value of the drug, if not of the peculiar sequence of its toxic effects. The dire results of crude doses have spoken eloquently to a host of adherents to a superior system.

It remained for Samuel Hahnemann, that most learned physician of his time, to indicate the better and entirely scientific use of the drug. Hahnemann demonstrated absolutely the force of *Similia similibus curantur*, and possibly in no case has the truth proven more valuable than in that of *mercurius*. The theories of men who were ignorant of this governing principle of the selection of drugs for the cure of disease have been swept away, one by one, after brief existence. Gradually the whole medical world is tending toward a full appreciation of Hahnemann's sound development of a beneficent doctrine.

To Hahnemann we owe the most valuable knowledge that

has ever been acquired concerning the action of mercury. It is a most significant fact, as well as striking evidence of the man's stupendous originality and independence of thought far in advance of his time, that he recommended the use of corrosive sublimate locally for ulcers, claiming for the solution (about 1 to 500) *antiseptic properties*. And this treatment advised by Hahnemann was also published by him some years before he announced his discovery of the law of similars.

The Father of Homœopathy and of Rational Medicine has, moreover, left us a legacy in his *mercurius solubilis* and *mercurius vivus* that will ever stand as a worthy monument to his attainments in science. The provings of these preparations as given by the master are complete and trustworthy, as shown by manifold experience since their publication. As we look at the unreasoning opposition that has been brought to bear against Hahnemann's work, it is impossible to ignore the irony of passing events. In a certain sense mercury is one of the curiosities of medicine. The estimation in which the drug has been held is one of extreme variety and instability. Only those practitioners who have been able to recognize a fixed basis for its therapeutic application have derived satisfaction from its use. However, it is now universally admitted that the medicinal virtue of the metal depends upon its fine state of subdivision, in which condition its particles still retain their globular form. For this minute subdivision either long trituration or shaking is necessary. Conversely, the fact is also appreciated that one pound of the pure metal has no action upon the human organism. Furthermore, "*A solution of 1 to 5000 is safe for anti-sepsis!*"

In vapors the metal causes nervous tremblings of hands and legs, shaking palsy, salivation, vertigo, and other disorders of the central nervous system. Hahnemann described for the world probably better than any one else the early mercurial symptoms, culminating in tenderness of gums, which indicates complete saturation of the system. Some authors speak of salivation as being the first symptom to appear. Hahnemann's list of symptoms from mercurial poisoning and provings has been confirmed and elaborated by the more recent investigations made with a dozen preparations of the drug for internal use.

The general characteristics of aggravation of symptoms at

night, profuse and offensive perspiration which does not relieve, rectal tenesmus, and frequently ptyalism with *thirst*, are common to all the preparations of mercury. The *dulcis* diarrhœa, however, has very little if any tenesmus; but tenesmus before, during and after stool is a marked characteristic indication for the *corrosivus*. The symptoms of cachexia, anæmia and œdema are also characteristic of mercury in general.

Pyrexia of mild degree, preceding the stomatitis, described by Hahnemann so fully in all its picturesque symptomatology, was the basis of the indications for mercury in the treatment of syphilis, a fact possibly lost sight of to-day. Mercurialization combined with syphilis or scrofula presents great difficulty, and it is universally admitted that large doses of the remedy do not cure syphilis. It must then be confessed that one of the modern problems is, how much of the antidotal treatment of mercurialism homœopathy is bound to do. There is certainly hardly any lack of uniformity of opinion as to the influence of the drug upon the healthy human organism.

The preparations of mercury most often useful are the *vivus*, *solubilis*, *dulcis*, *corrosivus*, *biniodide*, *protoiodide* and *cinnabaris*, or the *sulphide*. These have sixteen special centres of action through the great sympathetic nervous system, and furthermore have the power to invade every tissue of the body. All the glands—salivary, lymphatic, pancreatic, hepatic, especially—are easily affected by mercury. In hepatitis there may be stitches in the hepatic region, biliary colic, jaundice, dull pain in right hypochondrium, white or clay-colored stools, with less striking symptoms, which will indicate the *solubilis*, *dulcis* or *corrosivus*, according to the associated conditions. It is a significant fact that mercury impairs the bile-secreting function of the healthy liver; that is, it will act “as a cholagogue, though in health checks bile secretion.”

The nightly aggravation of pain, the chilling during evening and perspiration on the least exertion may be accounted for by the congestion and sluggish circulation of the portal system and general venous stasis. As a consequence of portal congestion, there is often compressive headache with yellow eyes, deafness, and a general sense of fullness. All the mercurials act upon the liver, the other glands, and upon the bones. The skin and the genitals are influenced by all excepting the *dulcis*.

Mercurius solubilis and *vivus* are indicated in pruritis, either general or local, aggravated at night and by warmth of the bed. These characteristics hold good in eczema, erythema, intertrigo, psoriasis and countless other cutaneous diseases.

The *solubilis* is indicated in gonorrhœa when there is burning in the urethra while urinating, and the discharge is yellow and purulent. A mucoid discharge calls for the *protoiodide* and green for *corrosivus*, the latter being specially indicated when there is a violent tenesmus of the bladder. Albuminuria and nephritis with scanty urine, containing often both blood and mucus—*corrosivus*.

Mercurius solubilis and *corrosivus* are often required in diseases of the female sexual organs. Intense inflammation of the vulva and vaginitis—*corrosivus*. Leucorrhœa, green, ex-coriating—*corrosivus*; yellow—*biniod*. Mastitis—*solubilis*.

The sulphide, or *cinnabaris*, is very useful in hydrothorax and in ciliary neuralgia. In the latter condition the pain follows the supraorbital branch of the trigeminus between the canthi. *Cinnabaris* is also useful in syphilitic iritis. The headache is right-sided, with pain from without in, while the *solubilis* headache is left-sided.

All the preparations have been found valuable in otitis media, and in rhinitis with suppuration and bone caries—(*biniodide*). Ozæna—*corrosivus*. Otorrhœa after measles—*vivus* or *solubilis*.

Mercurius dulcis may be needed in diarrhœa with bright, grass-green slimy passages, little tenesmus; but its chief usefulness is in Eustachian catarrh, with deafness and tinnitus, sticking and burning, especially left side.

The mercurials in general lack the rapid prostration of diphtheria, and do not cause diphtheritic membrane. The *cyanatus* is the exception, as it causes inflammation with white tenacious patches, like diphtheritic deposit. This tough, leathery membrane is unlike the fully-organized product of mercury generally. Thirty years ago physicians in Paris and St. Petersburg called attention to this "most potent anti-diphtheritic" *mercurius cyanide*, 3x dilution, especially valuable in asthenic, pytrid cases.

In diphtheria the *nitrate* of mercury is particularly indicated when the pains are sharp and splinter-like, with superficial

ulceration of the throat. There may be also cachexia, tremor, *subsultus tendinum*, and the sharp sticking pains characteristic of nitric acid.

The iodides act upon the glands and mucous membrane of the throat, somewhat like iodine, especially the *biniodide*, which has more glandular swelling than the *protoiodide*, and more fever, with cephalalgia. *Protoiodide* is right-sided, at least in the beginning, and the posterior two-thirds of the tongue is yellow, front clean.

Diseases occurring more often between November 1st and May 1st are met by the *solubilis* and *vivus*; e.g., catarrhal rheumatism, with chilliness; sore bones and muscles; throat inflammations; secondary syphilis with nightly bone pains,—though we are told that while syphilis attacks the flat bones, the action of mercury is upon the long bones only.

Mercurius corrosivus is highly irritating and destructive, essentially phagedenic in all inflammatory tendencies. This drug is particularly useful for diseases occurring between May 1st and November 1st. The indications for its use in dysentery are burning, tearing pains, prolonged tenesmus, with possibly cystitis, suppression of urine, hæmaturia, stools slimy and bloody, green mucus, *prolapsus ani*.

In severe cases of gastritis or in chronic gastric catarrh, with distention and soreness of epigastrium and transverse colon—*corrosivus*. Acute gastric catarrh, with weakness and tenderness at the epigastrium, thirst, nausea and bitter vomiting—*solubilis*. Ulcerative stomatitis, with fœtid breath, cancrum oris, odontalgia, with sensation of elongation of teeth, glossitis with thick, yellow, moist coating on tongue; a tongue showing imprints of the teeth, coppery taste in the mouth, swelling of salivary glands, all indicate the *vivus*.

The three great eruptive fevers, measles, scarlatina and variola; catarrhal fevers, worm fever, dengue and rheumatic fever, with sour-smelling night-sweats, staining linen; typhus, hectic, all may require some preparation of mercury, as determined by presence of the drug picture.

As mercurialismus frequently passes into pulmonary tuberculosis, with possibly supervening asthmatic symptoms, the *vivus* and the *iodides* are here useful. The cough may involve especially the larynx, and there is general catarrhal inflamma-

tion of the respiratory passages. A dry cough passes to the moist stage, with burning larynx, and is accompanied by acrid coryza, excoriating nose and lip, followed by muco-purulent expectoration.

Suppurating tonsils have been successfully treated with *mercurius corrosivus* 1x, locally. Ulcerating tonsils, with "sore throat" and inclination to swallow, should be treated with the iodides, as should the enlarged tonsils of quinsy or scarlatina. Chronic syphilitic angina, with tearing nightly pains and possibly white spots on tonsils, suppurating tonsils with sharp sticking pains in fauces, dry throat, aggravated by swallowing, liquids returned through the nose, demand the *biniodide*.

On the eyes the *protoiodide*, *dulcis corrosivus* and *cinnabaris* are especially useful. Though claimed by some authorities that mercury does not act upon the iris, the *corrosivus* is required in iritis, especially syphilitic, and where the degree of inflammation is more intense than under the *solubilis*. The *corrosivus* is also needed for rheumatic ophthalmia, with soreness, aching and burning. Other ocular disorders met by mercury are conjunctival and corneal inflammations, either ulcerative, phlyctenular or catarrhal, with photophobia, excoriating lachrymation; syphilitic or rheumatic retinitis, choroiditis, paresis of the recti, blepharitis, keratitis, and episcleritis.

The symptoms calling for mercury in meningitis are violent pains in spine, tearing in character, ameliorated by pressure. All cerebro-spinal disorders, including tremors, neuralgias, multiple sclerosis, acute myelitis, tabes dorsalis, call for mercury; and in paralysis agitans the drug, it is affirmed, has been curative. In the latter disease, however, with *cold* body, *heloderma* is the drug required.

Mercury affects the mind profoundly, and, as Hahnemann taught us, the mental symptoms of this as well as of any drug are the most important. All the mercurials have profound depression of spirits, dejection, and sense of wretchedness. The drug is said to have the power of restoring lost memory and of controlling delirium. It is uncertain whether the symptom of "hasty speech with abrupt finish" is very often verified in the patient requiring mercury, but irritability, worry, insomnia, mania and melancholia are characteristic of the *solubilis*, *vivus*, and other preparations of mercury.

From youth to old age this drug has the power of saturating every tissue of the body, when taken for a sufficiently long time. Prominent symptoms not already dwelt upon are cold extremities, offensive discharges, alopecia, aphonia, cardiac weakness.

Strumous adenitis, periosteal rheumatism, with nightly bone pains and pronounced intestinal inflammation extending, according to the best consensus of opinion, from the duodenum to the rectum, are most suggestive conditions for the selection of the drug.

Mercury acts directly upon the blood, diminishing its albumin and fibrin, also its red corpuscles. In syphilis mercury increases the number of red-blood corpuscles. Also in scorbutus, with spongy, bleeding and receding gums, the drug is valuable.

The extensive employment at present of the *protoiodide* for syphilis and the well-known sphere of the *biniodide* in throat disorders suggests the thought that in the latter combination the action from the iodine is the more prominent; as in the *cyanatus* the more striking influence comes from the hydrocyanic acid.

That our homœopathic materia medica comprises many drugs which antidote the toxic effects of mercury is a fact to excite gratitude. This materia medica is rich in remedies suitable to conditions for which mercury has too often been improperly selected. We must, therefore, be convinced that while the great polycrest possesses invaluable therapeutic qualities, their limitations should be recognized. Such a remedy, when inaccurately chosen, must produce pernicious results; while, on the other hand, it cannot be dispensed with when indicated.

These conclusions point to the belief that only so far as the indications for mercury, *in their totality*, are regarded in the light of a fixed law, will any prescription of the drug be successful.

CHRONIC DYSPEPSIA AND RETENTION OF URINE.—Prof. Zuckerkandl, of Vienna, states that dyspepsia and increased thirst may be associated with and dependent upon chronic retention of urine, which, as it may be latent in cases where these symptoms are present for some time, and seem intractable, it should not be forgotten to examine the bladder.—*Wiener Medicinische Presse*, No. 12, 1900.

A CASE OF DYSMENORRHOEA, AND A DESCRIPTION OF THE PATHOLOGICAL LESIONS FOUND AT THE CÆLIOTOMY PERFORMED FOR ITS RELIEF—(WITH TWO ILLUSTRATIONS).

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the New Jersey State Hom. Med. Society, at Newark, New Jersey, May 2, 1899.)

By dysmenorrhœa all will recognize an abnormally painful performance of the menstrual function. This unfortunate condition is so prevalent that many a physician would welcome any new means which promises to be effectual in giving relief to the patients who urgently look to him for the amelioration of their distressing ailment. While this paper does not aspire to satisfy any such expectations, I may hope to serve a purpose by suggesting that if the subject of dysmenorrhœa were regarded from a different standpoint than the one from which it is usually viewed, and the treatment modified accordingly, it would in most cases be for the welfare of the patients.

Before the advances in gynæcology had made possible the present successful application of surgical methods to abdominal diseases, many of the conditions in the abdomen and in the pelvis were the subjects of little more than speculation, for accurate information was not obtainable. In these days, however, and in accordance with the new light which has been thrown upon many of the pelvic lesions, especially of women, it becomes necessary to rearrange our views in a number of instances. In consequence, also, of the opportunities for more accurate information afforded by abdominal surgery, it has become necessary that a more accurate diagnosis of existing lesions be made than was done or was possible but a comparatively short time ago. Thus it has happened that one after another of the diseases usually classified as functional must needs be dropped from that list, and added to those recognized as resting upon appreciable and demonstrable organic lesions.

It will no longer suffice to adhere to the former classifications of the forms of dysmenorrhœa, especially if they are to be regarded as self-sufficient for the diagnosis of the conditions underlying the cause of the pain. Unfortunately, dysmenor-

rhœa has been regarded as a disease-entity, and the diagnosis of dysmenorrhœa having been made, the diagnostic problem is apparently too often assumed to be solved. Acting in accordance with the information furnished during abdominal surgical procedures, and by the pathology of gynæcological diseases, which has also recently been advanced thereby, we can no longer be contented with such a diagnosis, but cases must be individualized, and the attempt must be made to differentiate the lesions which lie at the root of the particular case in hand. This would appear to be the correct mental attitude to assume toward these cases, and a study of the pathology of gynæcological diseases must inevitably lead to a conviction of the correctness of this position. If this be true, then it follows that dysmenorrhœa is only a symptom of one or of a combination of several pathological conditions. This point has recently been given pronounced emphasis by Prof. H. A. Kelly (*N. Y. Jour. Gyn. and Obs.*, vol. iv., p. 408), who insists that dysmenorrhœa should never appear on the history-sheet as the diagnosis, but in every instance a much more accurate diagnosis should be made. He says, further: "It is of the utmost importance that the profession should realize that it is holding under treatment for dysmenorrhœa or pain a vast number of women who have pelvic tumors and inflammatory diseases. Years of fruitless treatment often pass before the real condition is detected and properly met."

It is certain that quite a number of cases of dysmenorrhœa may be successfully treated by therapeutic measures alone. But, on the other hand, it is equally true that there are a vast number suffering from pain in association with the menstrual period who have submitted to the earnest endeavors of able medical men without obtaining any relief, or only such as is but transient. These circumstances have given increased opportunity to the unprincipled to trade upon the misfortune of others by offering a multitude of nostrums, each one having the usual guarantee attached, and many of these preparations are endorsed by the names of those whose social position should be a guard against the furtherance of fraud. It is well known that the religious press is singularly culpable in presenting advertisements on subjects which are recognized as not fit for general household perusal.

There is another class of those who suffer from dysmenorrhœa

who have been led to seek relief by the use of palliative measures—palliative in the worst acceptation of that term—either of their own accord, or at the instigation of such physicians as believe that the main duty of the physician is to give relief from pain! It is not difficult for many of us to recall cases of women whose general health and usefulness in life have been sadly impaired by the use of vicious palliatives, not to speak of opium habitues and the less refined (?) conditions of alcoholic drunkenness in social planes where such are least expected. Against the use of morphia many eminent men have raised their voices most earnestly, but their warning is still too little heeded. That many women have thus become addicted to the opium habit is only too well known. Besides, it is doubtful whether anodynes ever exert any real benefit upon disease processes. Of the numerous new analgesics, Dr. A. Laphorn Smith has said (*N. Y. Jr. Gyn. and Obs.*, vol. iii., 568): “Since we have the anodynes of the coal-tar group, such as antikamnia, antifebrin, antipyrin, phenacetin, etc., the danger of forming a narcotic habit has considerably diminished; nevertheless no one who has used these drugs to any extent can say that they are totally free from injurious effects. The red corpuscles of the blood cease to carry oxygen, the muscles of the body, including the heart, are insufficiently nourished, and the activity of the nervous system is dulled, so that we cannot employ these drugs for any length of time without the patient being the worse for them.”

In respect to the therapeutic treatment of dysmenorrhœa, there is another matter which I would like to emphasize. While, as admitted, many cases are amenable to therapeutic measures, our knowledge of gynæcological pathology clearly points out the great harm which ultimately comes to the patient by the *interminable* attempts to relieve by therapeutic means alone, for during the time allowed to elapse while these are being applied, sometimes unreasonably protracted, the occasion vanishes when anything short of a major operation can be reasonably expected to afford relief. There certainly should be some limit to efforts of this kind, no matter how good may be the intentions of the physician. It is in these cases that harm is so often done by allowing to pass unanswered and unrebuked the injudicious and exaggerated allegations respect-

ing unnecessary surgical operating and unnecessary gynæcological treatment. All pathological processes have a beginning; and could these be more frequently recognized in their early stages, and then intelligently treated by appropriate means, which may even be in the nature of minor surgical procedures, it is absolutely certain that a very large number of the more serious operations, against which an outcry is sometimes made, would be far less frequently necessary than at present. I am certain that every operator could relate appropriate instances to exemplify the point which I am trying to make at this time.

If the premises be admitted, let us see to what conclusion they lead. Under the circumstances, if a patient suffering from dysmenorrhœa resists thoughtfully selected therapeutic treatment applied for a reasonable time, a careful internal examination should be instituted by one whose skill in diagnosis has been sufficiently developed to be able to recognize pathological changes in their incipency, and long before secondary lesions have complicated the case to such an extent that only a major operation holds out any prospect of ameliorating the suffering. While, as a rule, I do not advocate a hasty resort to vaginal examinations in the young, and am fully aware of the evils of instituting local treatment both in young women and before the use of intelligent efforts by other means, yet there are numerous instances of girls at puberty, and even of children, who have been afflicted by some of the most serious lesions met with in the adult. Nothing in these cases, not even youth, should deter from applying rational treatment, which necessarily demands, as a prerequisite, the obtaining of accurate information as to the conditions present. In many instances the rectal examination is amply sufficient; and a vaginal examination may be made, if properly performed, and all necessary information acquired, without rupturing the hymen. Of course a certain amount of skill is necessary, which in this instance is rarely a natural accomplishment, but one acquired by intelligent experience.

The case which I am about to relate has inspired the suggestions which have preceded. It is one which during fifteen years has been treated for dysmenorrhœa. It may not be possible at this late day to trace with certainty the several stages

of the pathological processes and the resulting changes which were found at the celiotomy, but we may do so with considerable probability. In my opinion the case merits recording because of the protracted period of the patient's suffering, during which time she was more or less constantly treated with drugs for dysmenorrhœa; and it is probable that had other means been applied years ago the operation performed could have been avoided in this particular instance; and also because all cases of a similar nature should be accurately studied, for here we sometimes touch upon pathological conditions which are not altogether clear, and unfortunately, in the present state of our knowledge, it has not been demonstrated as yet that some of them in their terminal stages are capable of being affected by medicines. It should be our constant endeavor to be able to recognize the cases of which this is true. I hope that it is not necessary to state that I am not advocating ovariectomy for all cases affected by dysmenorrhœa.

History of the Case.—Patient of Dr. F. E. Yerkes, Ambler, Pa., aged 35 years, unmarried. Puberty at the age of 12. Had no difficulty at first. When 20 years old, began to be affected with pronounced menorrhagia, and then severe dysmenorrhœa set in. Status præsens: Menses thirty days apart, lasting one week. On the first day the pain is dull, becoming sharp on the second day. The pains then become terribly severe in the abdomen, and go down the thighs; has pain also in the sacrum. Says the suffering is frightfully intense. Has yellow leucorrhœa, profuse, bland. Also has pains along the spine. Often gets diplopia, followed by temporal headache, going over the head and down the spine, where the discomfort is not so much a pain as a "bad feeling," and is followed by fainting spells. Patient says that she is gradually losing her memory. Has quite a sallow appearance of the face, occasionally greenish, and always very pale. She weighs about one hundred pounds. Appetite good. Constipation. From walking, easily gets out of breath. Has a mitral regurgitant murmur from any exertion.

During the fifteen years of this patient's suffering, she has received treatment from a number of physicians. For many years she has had morphia administered in very large quantities. Some of the coal-tar derivatives have been given, with

but little result. Homœopathic remedies have afforded some relief, but never satisfactorily.

Vaginal Examination.—Hymen intact. Cervix large, everted; granular erosion, bright red, and easily bleeding from any touch. Left ovary considerably enlarged, lying back of the uterus; is soft and sensitive. Fundus uteri anterior and much smaller than the cervix. Right ovary not much enlarged, and not so sensitive. The menstrual period came on in July, with the usual amount of pain.

Operation at the home of the patient. Median incision. Abdominal viscera in an apparently healthy condition. The enlarged left ovary was easily found deep in the pelvis, and adherent. Both Fallopian tubes were adherent by their fimbriated extremities in the posterior cul-de-sac, and in each there was a collection of clear fluid, so that they measured about an inch in diameter. The right ovary was small, somewhat globular, prolapsed, and adherent in the pelvis. Both tubes and ovaries were removed. The abdomen was closed by buried silver wire matrass sutures, continuous catgut suture for the peritoneum, and a subcuticular silk suture for the abdominal skin.

The operation was performed at 3 p. m. Patient apparently recovered thoroughly and rapidly from the anæsthetic (ether), but at 11.45 p. m. had a profound sinking spell. A vaginal examination made at this time showed that there was no secondary hæmorrhage into the pelvis. On the night of the second day the temperature was 102°, but the pulse always remained rather slow. Flatus was passed early, and the bowels were soon moved by the use of enemata and cathartics. The pulse and temperature gradually reached the normal, and the patient ultimately made a good recovery. It might be of interest to say that my nurse, who was most observing and faithful in the care of this case, was of the opinion that in this instance the 6th decimal dilution of arsenicum album, which was also administered to the patient, seemed to be of more use in relieving the patient from the condition of sinking, from which she suffered on the night of the first day after the operation, than any of the hypodermic stimulants which were applied. I count this unprejudiced observation as of considerable importance, especially since most of us are not inclined to

place much reliance upon the action of such a remedy in similar operated cases.

Description of the Specimens.—The day of the operation was quite warm, and the temperature of the room was consequently rather high. Immediately at the close of the operation the specimens were placed in a solution of formalin. In consequence of these facts the specimens were preserved in a most satisfactory condition. The left ovary measured about 2 by $2\frac{1}{2}$ by $1\frac{1}{2}$ inches. Its surface was deeply fissured, and there were a number of elevations, due, evidently, to several cystic follicles. One projection on the anterior inner portion was particularly prominent, and showed a distinct bluish elevation. The Fallopian tube of this side was considerably thickened and enlarged. Both tubes, as has already been said above, were found at the operation to be adherent in the posterior part of the pelvis, and were filled with a clear fluid. On making a section through the long axis of the ovary the ovarian tissue was found to be almost entirely occupied by four enlarged cystic follicles, while the lower part of the ovarian stroma was occupied by a cyst, into whose cavity a considerable hæmorrhage had taken place, as is well represented in photograph No. 1. On cutting across the tube of this side the walls were found much thickened, and the dendritic processes within were greatly increased in number.

The right ovary was considerably diminished in size, evidently cirrhotic. Its surface is traversed by many deep furrows, and the entire organ has a shrivelled appearance. Its longest diameter is less than an inch, and it approaches a globular form, and is hard to the touch. On section the structure of this ovary is found to be condensed, less vascular than normal, and only one cystic follicle is seen, about $\frac{1}{4}$ of an inch in diameter. The tube of this side is in about the same condition as mentioned in the description of the left tube.

Many microscopic sections have been made of these two interesting specimens. In examining some of these microscopic slides, the first point which attracts attention is the pronounced fibrous character of the ovarian cortex, associated with an absence of the evidences of maturing graafian follicles. A section through the blue spot referred to shows a corpus luteum cyst as described by Eug. Fraenkel, and beautifully illustrated (*Archiv. für Gynckologie*, Bd. 57, heft 3), and referred to as an

endothelioma by M. A. Dixon Jones and by Foerster (*Amer. Jr. of Obs.*, vol. xxv., 595). From without inward the structural elements here found are the thickened albuginea containing no follicles, either in it or beneath it. Then comes a looser connective tissue, perforated by numerous capillary vessels. Within this is a folded layer of cells resembling decidual cells of the endothelioma. Enclosed within the former cavity of the cyst is some remaining liquor folliculi, intermixed with old blood containing blood pigment. The large cystic follicle has flat epithelium lining in three layers, the innermost of which is a flattened epithelial layer, and corresponds to type 3 of L. Fraenkel (*Arch. für Gynäkologie*, Bd. 56, heft 2, page 359). Some of the smaller cysts, especially those near the parovarium, have columnar epithelium lining, similar to those of the membrana granulosa. The vessels of this ovary are quite large throughout. In some places on the surface of this ovary, especially toward the parovarium, the germinal epithelium is well retained.

The walls of the tube are thickened by inflammatory processes. The vessels are increased in number and in size. The dendritic folds within the tube are greatly increased in number, are rather thin as a rule, but in a number of places the hyperplastic changes of chronic endo-salpingitis are seen to have augmented the basement structure. The epithelial lining is well preserved. There are no evidences of purulent inflammation.

In the right or smaller ovary the microscopic appearances are somewhat different. The tissue is evidently cirrhotic. There is one cystic follicle, lined by flattened epithelium in hyaline degeneration, as described by Foerster (*Amer. Jr. Obs.*, vol. xxix., 145). The vessels of this ovary present an interesting study. They are quite numerous, are mostly small, and are very generally affected by endarteritis. There are many gyromata present. The differentiating qualities of the Van Giessen stain produce a most brilliant and variously tinted picture. In some places on the surface of this ovary the germinal epithelium may still be demonstrated. The same changes just recorded as present in the right tube also exist in the one on this side.

If we attempt now to study our case in order to trace the

progressive stages of the pathological process, the following bears the stamp of probability. As has been stated, the patient suffered from pronounced glandular erosion of the cervix. I am of the opinion that this condition is one which supervened at the time of or shortly after puberty. It may possibly be true that this condition was a continuance of a similar state normal to foetal and early infantile life, wherein the glandular epithelial structure of the cervical canal was continued to an abnormal extent out upon the portio vaginalis. The pathology of this



Posterior Surface of the Left Ovary.

condition is not fully understood. As the result of septic or gonorrhœal infection it is perhaps plainer. But if having the starting-point as I have indicated, it is comprehensible that the advent of puberty and the increased congestion and the associated discharges from the uterus and cervical canal formed a means whereby was furnished a column along which infection could have reached these glands and the endometrium.

There existed pronounced endometritis. This may have for years been the cause of the pain. The soft and readily in-

filtrated tissues at the internal os may have been the immediate cause. The imperfectly performed function of the uterus doubtless affected the Fallopian tubes and the ovaries. In the Fallopian tubes some form of infection took place, no doubt from the endometrium, for, as above stated, the fimbriated extremities of both tubes were found occluded, and the tubes themselves



Section Through Long Axis of Left Ovary.

in a condition of hydro-salpinx and chronic endo-salpingitis, the tissue changes of which have been referred to. The hydro-salpinx I regard as not very ancient, since the fimbriated extremities were not very securely closed.

By some of the various means by which inflammation is started in the ovary, it existed there. The evidences of chronic

oöphoritis are everywhere present. They show in the thickened tunica albuginea, in the inflammatory infiltration of the cortex, in the destruction of the graafian follicles, and in the cystic degeneration of about four which remain, as is seen in the cut surface of the left ovary in the photograph. In addition to these, there yet existed the corpus luteum cysts or endotheliomata which form such a prominent feature of the surface of the larger ovary. Throughout the ovaries, both in the parenchyma and in the medullary zone, are found endarteritis obliterans and arterio-sclerosis, forming gyromata. Further, there is the existence, readily distinguishable macroscopically, of a large and well-developed hematoma of recent origin, for the blood has coagulated, probably from the hardening fluid, and does not now completely fill the cavity into which it was effused; there has not as yet been sufficient time for its organization. These are conditions which Foerster (*Amer. Jr. Obs.*, vol. xxv., 577) has conclusively shown to be associated with painful ovaries. I would like to review his work in this connection for the purpose of emphasizing that statement, but lack of space prevents.

Under the circumstances, therefore, I cannot but feel that oöphorectomy was absolutely demanded in this case, for the tissue-changes already demonstrated were beyond the reach of therapeutic measures, and a continuance of their use would have unquestionably proved fruitless, and would simply have permitted the pathological lesions already present to advance to other and yet more painful and dangerous changes of the adnexa.

In conclusion, I would say that four days ago I had the opportunity of seeing and examining our patient. I found her much improved in appearance. The anæmic condition is rapidly disappearing. The pronounced blotchy yellowish color of the face has almost entirely vanished. The patient has materially increased in weight. She has no abdominal pain, and does not make use of morphia or other anodyne. There has been no return of the menstrual discharge since the operation. Leucorrhœal discharge, which was formerly so profuse, is now entirely absent. On vaginal examination I found the mucous membranes still anæmic, and a certain amount of atrophy of the genitalia present. The cervix uteri is flattened at the site of the former inflammation, but the latter has disappeared to such an extent that it may be considered as practically healed.

BELLIS PERENNIS—ENGLISH DAISY-BRUISEWORT—ON ITS USES IN OBSTETRICAL PRACTICE.

BY L. L. DANFORTH, M.D., NEW YORK.

MY attention was called to this remedy while perusing that entertaining and instructive little work by J. Compton Burnett of London, England, on "Organ Diseases of Women." Most of the remedies referred to in this monograph I know something about, but of *Bellis* I knew nothing, and I have not been able to find anything relating to the remedy in any work that I have consulted. I shall therefore premise what I have to say on the uses of this remedy by quotations from the work referred to.

Dr. Burnett says, "It often happens to ladies, when they are *enciente*, that they find it very inconvenient to get about, walking being very irksome and almost impossible. I mean, of course, when the cause of the trouble lies in the mechanical circumstances, and these are of a remediable kind."

In another place he says, "I sent a lady some *Bellis*, because, being very far gone in the family way, she found locomotion so very tiresome that a very short walk overcame her. A fortnight or so thereafter I received the following report: 'The *Bellis* did me so much good, I can walk quite well now, and do not get tired or stiff.' Here its action was prompt and satisfactory, with no inconvenient side-effect or after-effect, *i. e.*, truly specific. Why did I give *Bellis* in such a case? Merely because the inconvenience complained of was due to mechanical pressure; the tissues were pressed upon, and therefore in a condition precisely like that of a bruise; hence, I gave my old friend the Daisy-bruisewort; it acts upon the muscular fibres of the blood-vessels and upon the tissues, and thus clears the line of these mechanical obstructions."

Again he says, "A battered, bruised uterus yields quickly to anti-traumatics, such as *Bellis* and *Arnica*." Numerous instances are cited, in the course of this little book of Burnett's, where *Bellis* contributed its share toward the cure of the patient to whom it was given, and in all (some were distinctly gynæolog-

ical cases) I observed that the sore, bruised sensation in the pelvic organs was the predominating symptom upon which the remedy was prescribed.

Bearing in mind the suggestions of Dr. Burnett, it was not long before I had an opportunity to test the efficacy of *Bellis*. I attended a primipara whose labor was normal except that the second stage was unusually painful. The child's head was large, and as it descended and pressed upon the pelvic floor, and later upon the perinæum, it caused an unusual degree of distention of the tissues between the margins of the vulvar orifice and the bones on either side. The pain was excruciating, and chloroform was administered. The perinæum was badly torn in spite of the greatest care, but it was immediately repaired and good union obtained. After the usual time the patient began to get up, but convalescence was retarded and walking delayed, indeed was quite impossible for a time on account of the extreme soreness, a bruised sensation referred to the whole pelvis, more particularly of the muscles of the pelvic floor and perinæum. Naturally, arnica was given, but the patient did not improve. Different potencies of arnica were tried in succession, but improvement did not take place. It seemed as if the patient never would be able to walk. I then recalled the suggestion of Dr. Burnett, and gave *Bellis perennis*—five drops of the tincture every three hours—when, *mirabile dictu!* the bruised sensation disappeared like magic, and the woman was soon able to walk as well as ever.

I have given the remedy to women who suffered in the latter weeks of pregnancy from soreness of the abdominal walls and of the uterus, with most excellent results, when arnica had been insufficient to accomplish a cure.

I recently recommended this remedy to Dr. F. W. Hamlin, of this city, for one of his patients who was very uncomfortable on account of abdominal and uterine soreness, which arnica did not relieve. Dr. Hamlin has informed me that *Bellis* did its work well, and the patient was quickly relieved.

I have under my care now a lady who, after she was 35 years of age, had her first baby, which was delivered with instruments. The cervix, the vaginal walls and perinæum were terribly torn and bruised, and afterward became septic. In due time she was operated upon for a laceration; then another

baby came, which was followed somewhat later by a second very extensive operation for trachelorrhaphy, and perineorrhaphy, to complete what had previously not been as perfect a result as had been hoped for. The effect of all this was that the pelvic organs, the abdominal walls and the spinal nerves were tender to the point of almost absolute intolerance of touch, all suffering from traumatism.

The principal complaint was of *soreness of all affected parts*. Spinal remedies had been given with only moderate results. Arnica has been beneficial, but *Bellis* promises to complete the case.

It is therefore well named *bruisewort*, and vies with arnica as a remedy for the relief of sore, bruised sensations during pregnancy and after confinement, and will often succeed when arnica fails.

SOME PRACTICAL POINTS IN URINE ANALYSIS.

BY CHARLES PLATT, M.D., PH.D., F.C.S.,

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(Read before the Homœopathic Medical Society of Chester, Delaware and Montgomery Counties, Pa., February 13, 1900.)

A THOROUGH knowledge of the urine is of admitted value in the diagnosis of disease, whether of the kidney, ureter, bladder, prostate, or urethra; it is of equal, if not greater, value as an exponent of the more profound metabolic processes taking place within the body. Urine analysis is undertaken for the purpose of getting at this knowledge, and a competent examination is a most valuable aid to diagnosis. These points will be acknowledged by all intelligent men; but that which I wish now to emphasize, and which seemingly is not so generally believed, if one can judge from work done and opinions expressed, is that a careless or incompetent analysis is worse than useless, that it may not only fail to reveal the correct diagnosis, but may frequently *prevent* a correct diagnosis and lead to an erroneous one. Now, what are some of the conditions necessary to a competent examination?

First and foremost in importance, the collection of the urine for twenty-four hours and the analysis of an *average sample*

taken from the total amount passed. In no other way will the urine give a proper expression either of the body metabolism or of the condition of the urinary tract. The urine varies in composition constantly during the twenty-four hours. The urine passed in the morning, that passed at night, that passed before a meal, that passed after a meal, that passed during mental or physical activity, that passed during mental or physical rest, each has its own characteristics, and each differs from the others and from the average sample of the twenty-four hours. Not only are these differences quantitative, showing in varying amounts of normal urinary constituents, total solids, urea, chlorides, etc., but there may also be an actual qualitative difference as regards presence or absence of pathological ingredients. For instance, albumin may show in a urine after a meal and not in the morning urine, and yet it is the morning urine that is most frequently analyzed.

If, then, we are to learn anything from a critical examination of the urine, we must start with a representative sample, not with one taken at random. As we value the output of a mine by the analysis of a single piece of ore, as to judge of the condition of the body by a single passing of urine.

A knowledge of the *amount passed in the twenty-four* hours is equally essential to a proper diagnosis. There is nothing gained in determining the specific gravity, total solids, percentage of urea, etc., if we do not know the amount of urine passed. In fact, in such cases these determinations should be omitted, for, if made, they are apt to mislead. For instance, suppose we receive a sample, amount passed unknown; we determine the specific gravity, and find it to be 1.015. We call this a low specific gravity, and, as the specific gravity is an indication of the total solids, we think of low total solids. But suppose the patient had passed 3000 c.c. of urine; then the above specific gravity is really high, for it corresponds to a specific gravity of 1.030 in urine normal in amount. Or, again, suppose the specific gravity is found to be 1.040; this we say is high. But suppose only 400 c.c. of urine had been passed; then 1.040 is low, for it corresponds to a specific gravity of 1.010 in urine of normal amount. So, also, urea 0.8 per cent. we say is low. Maybe it is, and maybe it is not. Whether it is or not depends upon the amount of urine passed.

I know of no factor in the entire urine analysis the disregard of which has caused so much confusion and so much delay in the proper correlation of the results of the analysis with the pathology of the disease as this one factor just mentioned—the study of percentages in connection with a knowledge of the amount actually excreted. One would think that the collection of the sample involved labor on the part of the physician, and yet the trouble is not his; the physician has merely to instruct patient or nurse, and the proper sample will be brought.

I have mentioned the taking of the *specific gravity*. When the amount of urine passed is known, not otherwise, the specific gravity is often of suggestive interest in our diagnosis. In typical forms of Bright's disease, for instance, in acute parenchymatous nephritis, the amount is often decreased, the specific gravity increased; in chronic parenchymatous nephritis amount and specific gravity are both decreased; while in chronic interstitial nephritis the amount is increased and the specific gravity decreased. When amount and specific gravity vary together, both increasing or both decreasing, we must always have a pathological condition. When one decreases and the other increases, the condition may be either pathological or physiological.

For the calculation of the *total solids*, the most generally used method is to multiply the last two figures of the specific gravity by Häser's coefficient, 2.33, the result being grammes of total solids in 1000 c.c. of urine. A more accurate coefficient, as well as an easier one to use, is that of Loebish, 2.2. Even Trapp's coefficient, 2, is to be preferred to that of Häser. Those who use English measures may multiply the last two figures of the specific gravity by the number of fluid ounces passed. The result will equal, approximately, of course, the number of grains of total solids in the twenty-four hours' urine. Now, the proper amount of total solids is commonly given as about 60 grammes, or, roughly, 1000 grains. It should be remembered, however, that this value is for an adult male, between the ages of 20 and 40; of weight, 145 pounds (66 kg.). Do not expect 60 grammes from all ages and conditions. Women secrete less than men, and children less than women. For variations in weight, expect a corresponding variation in total solids. For variation in age, deduct one-tenth for patients between 40 and 50; deduct

one-fifth for patients between 50 and 60; and one-fourth to one-third for patients over 60. Then, again, if the patient has been on a light diet, or has been fasting for several days, deduct from one-tenth to one-third, according to the circumstances. For confinement to the house, deduct one-twentieth; for confinement to bed, deduct one-tenth. It is understood that these deductions must vary with the conditions, but they should always be borne in mind when interpreting the results of an analysis.

One other point in connection with the calculation of the total solids by means of a coefficient. In many pathological urines the results will be far from correct. It will sometimes happen, for example, in a diabetic urine, that the amount of sugar found by analysis will exceed the entire amount of total solids determined by calculation. In other words, the coefficient is not reliable when a urine departs materially from the normal.

Next in the properly conducted analysis comes the test for *albumin*. My attention is frequently called to "new" tests for albumin, some of them, oftentimes, highly recommended. The advertised value of these tests lies in the detection of the minute amounts of albumin, which, it is said, cannot be detected by the older methods. Now, such a claim is open to two criticisms. First, in many cases the reactions obtained are not due to albumin at all, but to other substances; in fact, many recently proposed tests show a most deplorable ignorance both of the chemical nature of the substance sought, and also of the reagents used. The second criticism I would make is that a trace of albumin so small as not to be detected by the old tests is not of clinical significance. This trace is supposed to be of particular interest in such conditions as chronic interstitial nephritis, where, as is well known, the albumin is frequently lowered to the vanishing point, but in all such conditions the detection of albumin plays but a very small part in the diagnostic picture obtainable from the complete analysis. I have quoted the terms "old" and "new" from common parlance; as a matter of fact, many of the "newest" of the tests are to be found in chemical literature of twenty years ago, and many of them recently hailed as discoveries should rather be styled exhumations.

Before testing for albumin the urine should be filtered, even

if apparently clear. For the *heat test*, a long test-tube should be three-quarters filled with urine, and the latter should be heated in its upper part until it just begins to boil. A cloudiness, ever so slight, will be visible when compared with the unheated clear urine below. Having obtained this cloudiness, add a few drops of dilute nitric acid—not acetic; if the cloudiness remains, albumin is present. The *nitric acid contact test* is made by floating the urine over concentrated nitric acid, using for this purpose a pipette, and avoiding most carefully any admixture of urine and acid. Small amounts of albumin may not be shown at once, therefore the test should stand for about fifteen minutes before deciding therefrom on the absence of albumin. The presence of albumin is shown by a white cloudiness appearing first at the contact between the two liquids, and then gradually spreading upward. Crystalline forms, color rings, etc., are to be disregarded. The *ferrocyanide test* is also useful. To a little acetic acid in a test-tube add two or three volumes of potassium ferrocyanide solution (1–12), and then add slowly an equal bulk of urine. A milky cloudiness or flocculent precipitate may generally be accepted as evidence of albumin. Tauret's test, Johnson's picric-acid test, the acidulated brine test, are not to be recommended.

For *sugar*, *Trommer's test*, with sodium hydroxide and cupric sulphate, is one of the best, but it is not generally so satisfactory in inexperienced hands as either Fehling's or Haines's test. *Haines's test* is, on the whole, probably the best for clinical purposes. A drachm of the test-solution is heated to boiling and the urine added, drop by drop, until eight drops in all have been introduced. If desired, the test may be made without heating, letting the mixed solution stand for twelve or more hours; but the test is then not so delicate.

In all common copper tests, whether Trommer's, Fehling's, Haines's, Purdy's or Pavy's, we must remember that the reduction may be due to substances other than sugar, and that unless these disturbing substances have either been proven absent or have been first removed, the copper test alone is not to be relied upon. Many methods have been devised by chemists to overcome this difficulty; for the clinician, however, probably the most practical method is to check the results of the copper test by means of fermentation. If the urine undergoes *fermen-*

tation with yeast, it is safe to conclude that the copper test was due, in part at least, to sugar present. On the other hand, it is unfortunately true that the fermentation test will not respond to small amounts of sugar, and it may be prevented even in presence of considerable amounts when the urine also contains mercurial salts, or derivatives of quinine, salicylic acid, iodoform, etc. As quantitative tests for sugar, for clinical use, I would advise Purdy's as a copper method, and Stern's as a fermentation method.

Urea is best determined by decomposition with a freshly prepared alkaline sodium hypobromite solution, using a modified Doremus ureameter. A stock solution of sodium hydroxide (6 or 7 ounces to the pint) should be kept on hand, and, for the test, to 15 c.c. of this add 1.5 c.c. of bromine. The bromine should be kept under water, and should be removed from its bottle by means of a glass finger-pipette. Those who object to the small amount of bromine vapor which may escape in this method may use for the test 25 c.c. of a good Labarraque's solution with 5 c.c. of 20 per cent. potassium bromide. The reaction in this case is a slow one, but the results are good.

Possibly it may be of interest to mention Fowler's method for urea, since it requires for its performance no other instrument than a urinometer. Determine the specific gravity of the Labarraque's solution and of the urine, then to one volume of urine add seven volumes of the Labarraque's solution. After several hours, take the specific gravity of the mixture. Now multiply the specific gravity of the Labarraque's by seven, add the specific gravity of the urine, divide by eight, subtract from this the specific gravity of the mixture after the reaction, and multiply by 0.77. The result will be the percentage of urea. Comparative determinations by the three methods named have given me 3, 2.9 and 2.9 as the respective percentages.

Chlorides are commonly determined by the addition of a silver nitrate solution, with the precaution that we must always first acidify the urine with dilute nitric acid. The determination is particularly interesting in febrile urines, when the chlorides generally decrease until just before the crisis, the latter being frequently announced by their reappearance.

Sulphates are determined by means of barium chloride after the addition of dilute hydrochloric acid. As the sulphates are

of metabolic origin, the determination is of particular value when the urea has not been tested for. It should be remembered, however, that the sulphates precipitated by the barium chloride in the test as described are only the so-called inorganic sulphates, and that the more complex organic sulphur compounds remain unprecipitated.

Phosphates, determined by the addition of magnesia mixture and ammonium hydroxide, are generally of less importance than other urinary ingredients; but in certain cases, as, for instance, in chronic interstitial nephritis, they have a diagnostic significance, in this particular disease being markedly decreased.

A few words as to the identification of urinary sediments. This is, of course, properly the province of the microscopical examination; but it may be worth while to remind the forgetful that much can be done in this line by easy chemical tests. Even under the microscope, chemical tests are frequently required to positively differentiate similar crystalline forms, or to recognize the character of amorphous deposits. In the absence of a microscope we may apply these same tests to the clouded urine directly, or, better, to the concentrated sediment obtained by the centrifuge or by standing. Warm the sediment with water; urates dissolve, phosphates, oxalates and uric acid remain undissolved. Acidify with acetic acid; phosphates and carbonates dissolve, the latter with effervescence; oxalates and uric acid remain undissolved. Acidify with hydrochloric acid; oxalates, phosphates and carbonates dissolve; uric acid remains undissolved. (Urates dissolve, but are gradually decomposed into insoluble uric acid.) Make alkaline with sodium hydroxide; uric acid dissolves; oxalates, phosphates and carbonates remain undissolved. (Earthy phosphates are precipitated.)

As regards the anatomical sediments, mucus, pus, casts, etc., acetic acid precipitates mucin and dissolves delicate proteid organisms. Nitric acid, if not in excess, precipitates proteid compounds. Sodium hydroxide dissolves mucus to a clear solution, while it changes pus to a viscous mass. Micro-organisms are also dissolved by sodium hydroxide. They may be readily recognized in a urine by a cloudiness not removable by ordinary filtration.

Such a table as this may, of course, be extended by including

the rarer urinary sediments, but it is not likely that a rare sediment would ever occur in sufficient amount to be recognized by any other than microscopical methods.

In this paper I have mentioned only a few of the principal urine tests, such as I believe to be most generally useful to the physician. One who has made any special study of the urine will think of many omissions—other tests for substances named, tests for substances not named, for etherial sulphates, for indoxyl compounds, for bile pigments and salts, for acetone, for acetylacetic acid, for peptones, etc., etc. Had I spoken of these, the intentions of my paper would have been exceeded.

THE CAUSES OF INSANITY.

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(Read before the Homœopathic Medical Society, State of New York, Albany, February, 1900.)

THE experienced traveller takes every measure to familiarize himself with the details of a proposed journey, in order that he may save time, money and annoyance, and thereby be better able to enjoy his travels. Such efforts are evidences of experience reflecting credit upon the prospective traveller's judgment and good sense, and the advisability of it requires no excuse, as the utility of the plan is self-evident. Could our lives be so directed as to avoid certain dangers into which we naturally enter, their whole tenor would be changed to our advantage. As it is, our pride and self-will force us into the by-ways of unsanitary living and unwholesome thinking, with thrifty Dame Nature exacting toll for every violation of her laws, which no one has yet been keen enough to outwit.

All men are not equal in their appearance, their physical strength, nor in their mental abilities, and the differences that exist in the harmonious adjustment between the physical man and the mental man are infinite in their possibility. In every one there is susceptibility to some peculiar influence, whether great or small, and it is frequently not recognized until some unexpected incident develops its presence.

The ability that some people possess to resist disease is, we believe, due to their constitutional strength. Now this may be lessened or impaired in any number of ways. Hereditary predisposition, about which they may know little or nothing, has a select variety of risks, with which she is willing to imbue the victim at the proper time. Previous disease may have left its mark, and this, too, must be considered as offering a complication for the future. A weak heart, imperfect assimilation of food, dyspepsia, an unsanitary dwelling or occupation, intemperance in any habit, a change of climate or of business, mental anxiety, an emotional life—all these have a marked predisposing influence upon the causation of disease. These conditions vary in quantity and in kind in the individual, and create an endless variety of tendencies.

It is seldom that parents appreciate the importance of mental hygiene, or make an effort for a child to study in such a manner that the best may be accomplished without an overstrain. The fact that one child may pursue its task with an easy comprehension of all that is demanded of it is no reason why another child can do the same thing with an equal amount of ease. The ignorance of this simple truth may lead an ambitious parent or teacher to make a misfit of the child, inducing early depression and consequent physical failure that ultimately destroy the usefulness of that child's possibilities in life. It is in this way that the weaknesses of children are developed, that they become known to us as the unbalanced ones, and when a sufficient strain is brought to bear upon them they break down, and enter the ranks of our State hospitals for the purpose of repair, or for unproductive existence.

Careless habits of thought are a form of intemperance of the mind that should be avoided, for they create an instability that, once established, years of effort can but imperfectly correct. It is from this unstable class that the greater number of insane come, and are forced to seek relief in a hospital. Were it possible for children to be taught to use their minds with the same material understanding whereby the muscles are developed in the gymnasium, the tendency to the development of insanity would be reduced in a marked degree. The necessity for taking life seriously is seldom appreciated until the ability to save from the general wreckage is down to a pretty small limit.

This "live and learn" method is an expensive one, and the old Greek who claimed that the wise man is he who corrects his mistakes by avoiding the errors of those he sees about him, taught the principles of a true philosophy of living. This is but a hint of what might well be said of the dangers of cultivating any habit that may cause mental confusion or perversion, as such states lead to a depression of spirits. Whether they will result simply in developing melancholia or paranoia, or will enter into that abyss of all human thought, dementia, the tendency of the individual alone can determine. The early teaching of methods calculated to develop concentration of thought, involving the exercise of judgment, reason and self-control, will save many from requiring care for mental troubles, although they may possess a strong nervous predisposition to insanity.

A school should develop the child's mental resources, whether those resources be above or below the average. It is not always from the brightest pupils of our schools that the best and most enduring work in life is to be expected. The homely adage of "Soon ripe, soon rotten," applies to children as directly as to fruit. A child who is slow in maturing finds that the inexorable demands now made upon him by our present school system cause a mental strain that saps his energies and steals away his ability to think, and, if continued, will create a habit of worrying that may destroy his chances of accomplishing anything at school. For this reason children are frequently forced to leave school at an earlier age than they otherwise would; and as it is not always possible to send them to a good private school, children who cannot meet the requirements now demanded of them are robbed of the priceless advantages of an education.

Mental strain brings about 20 per cent. of the patients to our State hospitals, and embraces depression of mind from death of friends, change in business and in life, exhaustion from disease, effort and shock, and worry that destroys the health of tissue in a manner only equalled by cancer. Mental unrest regarding religious subjects can lay the foundation for insanity in a degenerate as easily as any other bad habit of mind, for we must recognize that moral causes are as potent as physical in causing insanity. The causes which may induce an attack have as wide a range as the experience of a lifetime may permit. It is pos-

sible for the brain to lose several ounces of its texture and the individual evidence no insanity; yet a mental shock, that comes like a breath and is gone, may leave an intellect, bright before the event, clouded for the remainder of a lifetime. Any physical disease, functional disorder, shock or injury, anything producing an enfeebling physical and mental effect, monotony in life, intemperance in the use of liquor, in fact anything that may displace the natural harmony of the healthy adjustment in an individual, is sufficient to account for an attack of insanity in a patient of neurotic tendency.

In considering the causes that may induce a derangement of mind, we turn naturally to heredity, and expect from that source a satisfactory answer to our question. Studying the laws of heredity, we begin with that of inheritance; and here I do not think that a study of heredity in the brute creation, as shown by analogy, gives much accurate information about human weaknesses or tendencies. Time will demonstrate the truth that the quality of the human offspring is induced by the character of the mental and physical states of the parents at the instant of conception. When we remember the variability of moods and the changing physical conditions that exist in the most even-keyed of any one of us, and then consider what may result from a union of two people, finite reasoning and speculation come down to the old-fashioned plane of guessing.

It is usually considered that from 30 to 40 per cent. of the insane give a history of hereditary taint, but if the actual truth could be obtained, the per cent. would probably be much higher. There has been considerable discussion as to whether acquired peculiarities can be transmitted, and I believe the facts are sufficient to warrant the belief that they can be. When insanity exists in both parents, there is, consequently, greater danger to the child. When only one parent is affected, the influence of the father is believed by many to be much greater than that exerted by the mother. This may be illustrated by Michelet, who, in his celebrated work on "Love" (page 153), says: "Woe unto the children of darkness, the sons of drunkenness, who were nine months before their birth an outrage upon their mother. He who is born of a nocturnal orgie of the very forgetfulness of love, of a profanation of the beloved one, will drag out a sad and troubled life." It is also recognized that

children born of fathers enfeebled by old age and mental exhaustion show little or no evidence of the mental strength that characterized their parents when in their healthy vigor. The greater harmony there may be between the parents at the instant of conception, the more likelihood there is of the child representing the best mental and physical traits possessed by the parents.

Emotional strain is liable to develop insanity in those who may be broadly classed as degenerates. They are the unbalanced; those who are actuated by impulse, who live in the joys of the present, who cannot say "No," who reflect the atmosphere which they happen to breathe, whose motions are nervous, who lack self-control, and those generally who have the nervo-sanguine temperament; those who have not been taught to think properly, who are possessed of no ability to concentrate their attention, those in whom the power of continuity has never been developed, and with whom any attempt to reason fails, owing to prejudice and inability to co-ordinate thought.

Intemperance in the use of liquor has, in the minds of many, furnished more insanity than any other cause; but this cannot be accepted as true from existing facts. Degenerates are peculiarly susceptible to the action of alcohol, and intemperance has attracted attention as a cause when it is only a result, the drinker being strongly predisposed to insanity in the first place, and a tendency to drink being an exhibition of his stigmata. Consequently, we consider drunkenness to be more frequently a result of inherited predisposition to some form of insanity than a cause by itself. It is probable that 10 per cent. is a very liberal estimate for intemperance as a cause, and, could the facts be secured, 3 per cent. might be found to represent the truth more accurately.

When we affirm that "like begets like" we do not mean that the general character of the parents is always represented in the children, but we mean that the status of both parents at the time of conception determines the general character of the progeny, and that the progeny consequently represents the mental condition of the parents at the time he was conceived. Depressed or perverted physical or mental states in the parents will tend to develop and exaggerate these same defects in the child.

There is a strong impression held by many that marriages of consanguinity lead to marked defects, as deaf mutism, blindness and idiocy. If the parents possess marked weaknesses, there are likely to be defective children here as elsewhere; but this subject is still under dispute, and many honest observers declare that when the parents are sound, and show no signs of degeneracy, the children are as free from defects as though no relationship existed between the parents.

We have been told that it requires three hundred years to grow a fine lawn in England, and Sir William Atkins must have unconsciously paraphrased this when he said that a family history including less than three generations is useless, and may even be misleading. When we consider how few of us are able to give a reasonably fair analysis of our ancestors for two generations back, it will explain the incredulity that forms itself into honest doubt regarding the value to be attached to statistics concerning the causes that lead to insanity, gathered, as they are, from the masses, to whom the subject of accuracy is of small importance. One must recollect that these causes are subtle, and that they pertain to the inner life, not only of the individual who is insane but of his ancestors, even unto the third generation.

When we consider the rapidly changing mental states that characterize humanity, and know that it is not alone one, but the union of two conglomerations that determines the character of the unborn third, we crudely perceive that the product may easily represent a type not wholly like either parent, but rather a composite possibility of ancestry. The better physical and mental health the parents possess, coupled with a harmony in spirit, the more likely is the offspring to be thankful in after life for having had a goodly heritage. As this statement refers to the conditions at the instant of conception, the effect of too early parentage, as well as of the late in life, can be appreciated. Both lack the tense fibre calculated to endure and to resist wear.

The great emotions of life do not cause so great injuries as the trivial ones that are often repeated. These leave their marks upon the brain and distort the life. Overwork of the mental faculties seldom causes insanity, but the habit of worry lessens the energies of every organ, as well as of the vigor of

every intelligent impulse. We frequently find that worry is a cause of insanity. This habit of thought is the natural result of many causes. It may arise from a temperament that is of a finer grain than those with which it is forced to associate, and the rebuffs which it daily meets tend to habits of introspection, with the inevitable result of establishing the habit of worry. Worry accompanies and directs the thought in every case of disappointed ambition, crowding out hope and attempting to kill every project by its ungodly pessimism. In this way it is possible for any emotion to commence, continue and become an enduring thought, to paralyze the ability of its victim, and to allow insanity to terminate the life.

The death of a relative, involving, as it frequently does, a change in the relationship of living; psychical pain that never secures an outlet, but is endured patiently and without complaint; any morbid sensation, frequently repeated, that excites the emotions, are sufficient to induce insanity in one who is strongly predisposed to it.

Impure thoughts are as demoralizing and as exhausting to the physical and mental strength as a life of actual debauchery, and one who so indulges lessens the duration of healthful sanity. Pernicious habits of thought are as dangerous to indulge in as are any other bad habits of life. We recognize the glutton and deplore his grossness; we view with pity the callow youth who is mortgaging his health of body, mind and soul in sowing wild oats under the belief that he is acting a manly part in this hustling world; we view the acts of the future drunkard as one who is demonstrating the possession of his neurotic taint, and wonder at the ease with which, as a degenerate, he unerringly seeks the companionship of his kind; but the mental moods are not so easily recognized. The practice of building air-castles in which self plays an important part, and where the imagination and the emotions exhaust their respective resources in outdoing each other, while judgment, reason and will-power become so enfeebled by inactivity as to be unable to exert an intelligent controlling power in an individual life—all these will silently and easily develop into insanity as surely as any other cause.

From the annual report of the State Commission in Lunacy for New York State, showing the assigned causes of insanity in

those admitted during the year ending September 30, 1898, we give the following percentage of the moral and physical causes that led to the admission of 5542 patients—2764 men and 2778 women :

Moral.	M.	F.
Adverse conditions, death of friends, business troubles, etc.,	8.50	9.18
Mental strain (worry and overwork not included in the first given cause),	5.97	6.55
Religious excitement, . . . . .	.75	1.08
Love affairs, . . . . .	.83	1.30
Fright, . . . . .	.65	1.30
Physical.		
Intemperance,*	15.23	4.57
Sexual excess, . . . . .	.11	1.01
Venereal disease,	4.23	.79
Masturbation,	3.25	.46
Sunstroke,	2.02	.43
Accident or injury,	3.47	1.04
Pregnancy, . . . . .		.12
Parturition and Puerperium,		3.92
Lactation, . . . . .		.68
Change of Life,		3.09
Fevers, . . . . .	.33	.25
Privation and overwork,	1.08	.75
Epilepsy,	3.29	2.99
Other convulsive disorders, . . . . .	.14	.11
Diseases of the skull and brain,	1.59	.61
Old age,	4.59	4.50
Exophthalmic goitre, . . . . .		.04
Epidemic influenza, . . . . .	.58	.90
Abuse of drugs, . . . . .	.80	.58
Loss of special sense, . . . . .	.14	.04
All other bodily diseases,	3.69	6.73
Heredity, direct,	4.23	6.12
Congenital defect, . . . . .	.94	.88
Unascertained,	31.22	39.74
Not insane, . . . . .	.98	.83

It is interesting to remark that inherited predisposition to moral causes was in men 2.31, and in women 2.81; in mental strain the percentage was 1.51 in men, and women 2.12; in intemperance the percentage was 2.71 in men, and women 1.06; while the inherited predisposition found in all of the cases admitted was 19.93 in men and 23.29 in women, or an average of 21.61.

* This percentage is too high, owing, I believe, to reasons previously given in this article.

The difference between these statistics and some European estimates may perhaps be explained on the ground of our changing population, and from the fact that many of the patients committed to our State hospitals, being of foreign birth and knowing little of their ancestry, are consequently unable to give accurate statistical family histories.

TREATMENT IN THE TERMINAL STAGE OF CHRONIC INTERSTITIAL NEPHRITIS.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

It is not within the scope of the present paper to discuss those cases of nephritis which are secondary to an insufficient heart. As a rule, these can be recognized by the fact that when cardiac compensation is re-established the kidney lesion becomes latent.

It is, instead, with cases primarily renal, those in which the changes in the kidney have been sclerotic from the very beginning, and in which the heart has become involved only through its efforts to compensate for the kidney inadequacy, that we shall deal.

Let us assume in a given case that long since we have recognized the cardio-vascular changes, the hypertrophied heart with accentuated second sound at the aortic orifice, the tense pulse and rigid arteries, and the associated nervous symptoms, which, with certain urinary changes to be described, constitute unmistakable evidence of a contracted kidney. By repeated examinations we have found that the renal excretion is large in quantity, of low specific gravity, and occasionally slightly albuminous; and with the microscope we have demonstrated the presence of at least a few hyaline casts. The patient has continued to live on in apparently fair health, however; he may have lost a little flesh, he may have suffered occasionally from digestive disturbance, he may have complained of other minor ills, but there has been no development in his symptoms to indicate that his condition has changed for better or worse.

Yet all this time his heart has been growing. Gradually, fibre by fibre, it has added to its bulk; ounce by ounce and pound by pound it has increased its propulsive power in order to overcome the sluggish action of the renal cells and the obstruction in the vascular system. The hypertrophied heart becomes enormous. It is, indeed, like that of the ox—the *cor bovinum*. It cannot go on forever. Perhaps a brittle cerebral artery will break, or some other accident terminate the struggle abruptly; but if that does not happen, a point must be reached when the heart can grow no more—it must yield. Then, since lesions of kidney and of heart rarely progress at the same rate, the termination will be according to the more advanced degeneration of one or the other. Two courses are possible.

The keynote of the first of these is uræmia. The patient may have been one presenting few symptoms; possibly a little dropsy, some puffiness under the eyes or about the ankles, and that is all. Suddenly, often without warning, comes stupor or coma, or it may be uncontrollable vomiting or hiccoughs; often there are convulsions, and then death is seldom long delayed.

There are patients with a high degree of renal atrophy and with a heart able by its exertions to compensate for a long time for the defect in the kidney parenchyma. When at last the heart does fail, already the kidneys are so inefficient that an almost acute retention of waste matters occurs, with a consequent fatal poisoning before the accumulation of water can lead to other symptoms. With the onset of uræmia we must abandon all hope of more than temporary relief. “The pitcher is broken at the fountain;” the end is near, and death cannot be long delayed. Yet these patients may rally from the attack and live for some months in comparative comfort, and it is our duty to aid them as well as we can by urging what remains of the renal epithelium to take up its task again.

Of the many measures recommended for relief of the uræmic attack, all have one object, the elimination of the poison. Blood-letting, purging, sweating and diuresis, have each their advocates, and often, it would seem, on most irrational grounds. Bleeding must be advised theoretically; I can find no worthy testimony to its good results. Purging may have some elimi-

native value. I have administered two drops of croton oil in a teaspoonful of plain oil, and have thought that the resulting catharsis hastened relief. Moderate sweating, such as may be brought about by warm covering and perhaps a few hot bottles, may do good; but the extreme, drenching sweats produced by the action of such drugs as pilocarpine, it seems to me, do absolute harm. Lessening of the fluids in the body is too apt to concentrate the toxins, while jaborandi and its derivative are dangerous heart depressants. As to the ordinary diuretics, their action often increases the amount of watery rather than excrementitious and toxic substances thrown off.

In short, it would be better to use measures for the direct elimination of toxic substances, rather than the indirect methods that have been mentioned, and I believe that we have such agencies at our command. Of medicines, in the past I have seen benefit follow the administration of grain doses of *mercurius corrosivus* in the second decimal trituration every hour until improvement was manifest. Latterly, however, I have abandoned other remedies for the arsenite of copper, giving one or two grains of the second decimal trituration every half or quarter hour until relief is obtained; and I have come to believe, with Goodno, that when it fails we can expect little from other drugs. Its action is not diuretic in the ordinary sense; I have never seen any immediate marked increase in the total quantity of urine excreted. Its action seems rather to be exerted upon those renal cells having to do with the elimination of the poisonous products of metabolism.

In this connection we must emphasize the value of the normal saline solution, used either in the form of copious colon enemata or by intravenous injection. This dilutes the toxic blood and incidentally stimulates renal activity. A vast accumulation of clinical experience demonstrates the soundness of the reasoning that led to its use.

It scarcely seems necessary, in concluding our discussion of uræmia, to dwell upon the need of care after the attack. Attention to the patient's food, clothing and climatic environment—details so important in the management of any stage of nephritis—now becomes even more essential. Especially does the activity of the eliminative organs, the skin and gastro-intestinal tract, as well as the kidneys, become a matter of solicitude to the medical attendant.

In a large proportion of patients suffering from chronic interstitial nephritis, however, it is the heart and not the kidneys that reaches its limit first. In these cases there is not the advanced renal atrophy, the excretory power is not fatally diminished; but the heart, whether it be as the result of valvular lesions pre-existing or due to atheroma, dilatation, myocardial degeneration, or of faulty innervation, weakens. Let not this statement be misunderstood. The heart is not absolutely weak, it is only relatively so. It is still strong as measured by ordinary standards; in fact it is often excessively powerful; but it is relatively incompetent in that it cannot propel the blood through the altered arteries with sufficient vigor for the wasted renal epithelium to abstract from it the necessary quantity of urine.

As a result, there ensues the melancholy phenomenon that characterizes the heart failing from any cause: venous stasis, with dropsy, beginning over the instep, and little by little filling the intercellular spaces in the dependent parts of the body. Day by day it rises higher, and if hydrothorax or hydropericardium does not quickly intervene, the patient may drag through weary weeks and months of dropsy and dyspnoea, to finally perish miserably, "drowned in his own fluids."

We can recognize the situation easily: the suffering patient, often unable to lie down for rest, and starting from his first sleep in an agony of "air hunger;" the increased frequency of a respiration that is loud, sighing, even moaning; the rapid pulse, with its increasing weakness and irregularity. Surely such suffering demands the best that medical science can offer; and here, as sometimes in the uræmic cases, we may mitigate the torture, and for a time postpone the inevitable end.

As in any case of cardiac incompetency, the first necessity is rest, if possible in a recumbent position. The diet should be simple, digestible, and limited as to the quantity of liquids. Even though it be prejudicial to renal activity, it is necessary to closely limit the ingestion of fluids until every vestige of dropsy has disappeared. Before the latter can be brought about, however, the frightful dyspnoea may demand relief. Morphia, which acts so well in cases primarily cardiac, is not less valuable in relieving breathlessness here; but its unfortunate tendency to check renal activity leads us to avoid its use

if possible. On that account I have tried heroin in doses of one-twelfth grain, and I find that it gives considerable relief without perceptibly affecting the excretion of urine.

The first indication, then, is to get rid of the dropsy. Here is the case for diuretics, but they cannot be relied on as in purely cardiac accumulations. Apis, which often acts well in acute nephritis, is of little value in the chronic form. Either digitalis or apocynum, in doses of ten, fifteen or twenty drops of the effusion every two hours, may do the work. Be careful lest the dose be too large and produce gastro-intestinal disturbance. Wait several days, if necessary, for effects, rather than increase the dose. Then, if there is still no decided increase in the amount of urine, it is better to change to another remedy; and of all the diuretics, calomel alone seems to act as well in renal as in cardiac dropsies. Begin with small doses, a grain of the first decimal trituration every two hours. Do not increase the dose until you have waited at least two days for effects to appear, and then add but little at a time to the amount given. Avoid the cathartic action of the drug if possible; its diuretic action will be the better. Remember that long continuance of the administration of calomel, even in these small doses, may give rise to salivation. The latter is brought about largely by the local action of the drug, and on that account it is advised that the remedy be given in capsules or compressed tablets, and the mouth be rinsed immediately with clean water.

These three drugs have been mentioned because, unlike many other well-known diuretics, they seem to retain their efficacy in dropsies of renal origin. I have tried others only after these had failed, and perhaps on that account I have had little experience that would encourage me to continue their use. For instance, in my hands theobromine has been unavailing. Yet a physician in whose clinical observations I have great confidence has reported marked benefit following the use of that drug. His method is to order twelve two-grain powders, administering four of these at intervals of two hours, four at three- and four at four-hour intervals; and rarely has he found it necessary to use the entire twelve powders. I have also used, and with little effect, diuretin, whose only advantage over theobromine would seem to be its greater solubility.

Caffein, whose double salts, the natro-benzoate or natro-salicylate, may be preferred to the citrate because of increased solu-

bility, has occasionally given good though rather transitory effects. Spartein sulphate, even in large doses, has been a disappointment. As a last resort, should medicinal therapeutics fail, it becomes necessary to drain the lymphatic spaces by puncturing the skin. This is best done with a large-sized needle upon the posterior aspect of the leg, surgical cleanliness, with all that the term implies, being essential to the procedure. The leg should then be covered with sterilized cotton, wrapped in oiled silk, and the dressings renewed as often as they become soaked.

Thus far I have discussed only the measures aimed at removing the dropsical accumulation. When that is accomplished our treatment is only fairly begun. It is necessary to sustain the heart and prevent the reaccumulation of fluid. Small doses of diuretics may be needed for some time. The classic heart-tonics may all be called on in turn. Digitalis, here given in the so-called "tonic doses" of not more than ten minims of the tincture every twelve hours, is certainly the most reliable, although it cannot be depended on as in purely cardiac cases. In these cases it is well to associate it with glonoin in order to dilate the arterioles and relieve vascular tension. For this purpose begin with one-drop doses of the first centesimal dilution and increase the dose to the physiological limit. Do not administer it in combination with digitalis; keep the remedies separate, and vary the dose of either according to the requirements of the case.

On several accounts strophanthus should be preferable to digitalis in these cases, and in some instances it has proven very beneficial; but on the whole it has been unreliable. Of the other heart-tonics, such as convallaria and adonis, I am unable, through lack of extended trial, to form an opinion. My impression, however, is that they are better adapted to the treatment of primary heart lesions in which the right ventricle is particularly concerned.

Recently I have given a somewhat extended trial to the artificial Nauheim baths, and the results have been very satisfactory. It has been my custom to order a series of twenty baths, intermitting every fourth day. The temperature of the water, originally about 94° F., has been gradually lowered and the duration of each bath increased by one minute daily until the original five minutes have become twenty. At the same time

light gymnastics, consisting of extension, flexion and rotation of legs, arms and trunk against the carefully applied resistance of an attendant, have been prescribed to as great an extent as the skill of the latter would seem to justify. Not only has the condition of the heart itself improved greatly in consequence, but the intense nervous symptoms common in this disease have been completely relieved. As yet it is impossible to say that these baths are applicable to every case, but it is my belief that wherever the myocardium is at fault they should prove beneficial.

As soon as we have secured the re-establishment of compensation, if indeed we should be so fortunate, it is well to substitute for the "heart-whips" other drugs whose action, if not so immediately exerted, is more permanently beneficial. Such of these as cactus, arsenic and arsenic iodide have a peculiarly beneficial action on the myocardium; while strychnia acts particularly through the nerve-supply of the heart. I have also used strychnine arsenate and strychnine phosphate, both in grain doses of the second decimal trituration, and have thought that thereby I secured an action on both muscle and nerve-supply.

In this somewhat superficial survey of a wide field I have, I know, omitted many important details. The use of atropine sulphate in doses of $\frac{1}{100}$ or $\frac{1}{60}$ of a grain hypodermatically to control pulmonary œdema, and the use, if necessary, of astringents, preferably tannigen in ten- or fifteen-grain doses, to control an exhausting uræmic diarrhœa, are points worthy of mention.

Lastly, it must be said that all cases in the terminal stage of contracted kidney do not fall into one or the other of the groups that I have described. A few perish with symptoms suggesting angina pectoris, and in others the symptoms may blend, heart and kidneys failing together. Then the outlook is dark indeed; but we can still find comfort in doing what we believe to be best for our patient. If I have made little mention of the therapeutic methods peculiar to our school, my excuse lies in the fact that we are dealing with conditions essentially mechanic or toxic, and demanding corresponding measures for their relief. We are fighting, at best, a hopeless fight. To hold back death, to palliate, for even a little while, is to do well.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE DIETETIC TREATMENT OF DIABETES MELLITUS.

WE have always failed to see how the withholding of carbohydrates from the diet of diabetics, in order to cause the sugar to disappear from the urine, could in any sense be regarded as a therapeutic measure, *per se*. It is, at best, but an adjuvant to other lines of treatment. If the system ceases to eliminate carbohydrates simply because they are not furnished, no very great advance has been made in the curative treatment of the deficient power of assimilation which must be recognized as the fundamental cause of the symptoms.

In spite of its unsatisfactory and illogical character, the symptomatic or dietetic treatment of diabetes mellitus (Ernährungstherapie of v. Noorden) seems to be the only one left to modern medicine, in view of the very little positive knowledge possessed at the present day regarding its etiology. Homœopathy is not in exactly the same position as is the other school of medicine. It is not influenced to the same extent by the real or fancied knowledge of the etiology and pathology of disease. Its symptomatic treatment, if properly and thoroughly carried out, will lead back inevitably to the cause and source of the symptoms, and, if possible, remove or modify them, even if they remain unknown. And yet, in the case of diabetes mellitus, our success in removing the glycosuria by remedies, without the aid of diet, has not been particularly brilliant. Without being willing to acknowledge, with the writer of a paper on The Modern Treatment of Diabetes Mellitus (*Medical Record*, May 12, 1900,) "that the medical therapy by drugs has shown itself in nearly all cases, by careful scientific investigation, to be a failure as far as the patient is considered," we feel that we should be ready to make use of any auxiliary treatment which promises good results. Such we will find in the

nutrition or dietetic treatment of v. Noorden. In the paper referred to above we find a clear and concise statement of its principal points. It seeks to combat the main symptoms of diabetes, viz., the glycosuria, and the malnutrition caused by the constant loss of non-assimilable nutritive material. The first object sought is to discover the personal equation of each patient as regards his "tolerance for carbohydrates." This is done by means of a "standard diet," containing a known amount of carbohydrates, and by the subsequent careful analysis of the urine of the succeeding twenty-four hours. The full amount of carbohydrates which the patient has proved himself capable of assimilating is then allowed.

Where the glycosuria is persistent it may be necessary to resort to periods of the strictest diet, as nearly free from carbohydrates as possible. The reduction to this diet is to be made gradually and with care, so as not to interfere with the general nutrition too seriously. These periods of strict diet are to last from three to four days, or longer, until all traces of glycosuria have disappeared. Should this result not be attainable by these means, it may become necessary to restrict the amount of albuminous food, and to substitute fat with certain vegetables which contain a very small percentage of carbohydrates. During this dieting careful examinations of the urine are required, to detect the existence of azoturia, the percentage of acetone, and the presence of diacetic or oxybutyric acids. To avoid hyperacidity of the blood, large quantities of the bicarbonate of soda daily are recommended. After the glycosuria has disappeared, small amounts of carbohydrates are again added to the diet up to the point of tolerance. At intervals, varying according to the severity of the case, periods of strict diet of four or five days are to be enforced each month, or every second month, since it has been demonstrated that periods of abstinence increase the assimilating power, while indulgence in carbohydrates diminishes the same.

Based upon this latter fact, such carefully and scientifically regulated diet approaches more nearly a true curative treatment than the usual haphazard "putting upon a diabetic diet" so much in vogue, no matter what medicinal agents may be simultaneously employed.

Even if, in a general practice, and amongst the majority of

diabetic patients, a strict carrying out of all the provisions of this dietetic treatment may prove impossible, there are enough suggestions contained in it to cause us to modify considerably the usual routine treatment of these cases.

LONGEVITY.

Is a long life in itself desirable? From the local and newspaper-disseminated *éclat* that attends the reaching of an unusually old age by some weary mortal, it would seem as if it was supposed in some way to confer a peculiar honor or distinction, or was a specially precious boon bestowed only upon a favored few. Now and again we find instructions given as to the best means of prolonging life—instructions which, if conscientiously followed, would go far to reconcile most of us to an earlier demise, since the life they would give us would scarce be worth the living.

Wherein lies the true value of life? Surely not in the mere living—in the state of being not-dead. Life's value depends upon the extent to which it is filled with the reflex consciousness of unimpeded exercise of all the functions and faculties of mind and body. It has never attained its full value where any of these functions fail to be brought into action, and it begins to lose its worth as the power to exercise them diminishes or is lost. A slight inkling of this truth is seen in the attention always drawn to the fact that the aged loiterer is in "full possession of his faculties." This reportorial statement usually means that he can still eat soft food; can see to read, by the aid of spectacles, the large print of his Bible; has a retentive memory for the events of his youth, and a garrulous tongue, which never tires of repeating them. But sometimes not even these scant residues of a full life are included, and what can be said of the worth of a life which possesses even less?

Although there seems to be a natural repugnance to dying, and a wonderful clinging to life even after all has been lost which would make it desirable, yet these are sentiments begotten and bred by civilization and false religious notions. Among barbarians and the less cultured peoples life is held

very cheaply. Death amongst such has but few of the terrors which it possesses for the civilized. With no unnatural dread of the uncertainty of the future, they willingly surrender life when it ceases to realize their hopes. It is not, therefore, life as counted by years that we should learn to prolong. We should cease to regard death as the end of our life, and only learn to live the fullest, completest life here and now, be it for a longer or shorter period. To do this we need only apply universally to all our faculties the principles which we now apply in a restricted measure to some. It is simply a question of use, disuse and abuse, coupled with the universal law of the conservation of energy. No faculty or function is to be neglected; each one is to be cultivated, developed and exercised, with due regard to the amount of energy at command. Dissipation of energy in fruitless worry or in aimless activity tends inevitably to detract from the fullness of the enjoyment and the value of the life we lead. Excessive cultivation of one or the other side of our nature—we are all many-sided—will lead to disuse of the others, and their consequent atrophy and decay with advancing years. How many of these specialists do we not find among the aged? We see the emotional specialist, the rational specialist, the intellectual specialist, the sensual specialist, and others according as one faculty has been unduly cultivated, to the neglect and subsequent loss of the others.

The intense characteristics of the present age are not calculated to promote longevity, not by reason of the varied activities required, but on account of the friction between them, due to their improper regulation. Life is fuller of possibilities now than ever before, but few of us know how to seize and appropriate them. By a systematic ordering of all our activities, and by a universal sympathy, which, while it dispenses life about it, draws from its surroundings renewed vigor and vitality, we will be able to live much, if not long; and far better is a short but full life than a long, attenuated existence, ending at last, like a candle, in the sputtering and flickering of a "remarkably aged" dotard.

Self-development in all directions will not only increase our own capabilities for testing the full value of life, but will prompt to works which will give us true longevity, be our own individual span of life short or long.

THE AMERICAN INSTITUTE MEETING AT WASHINGTON,
JUNE 19, 1900.

THE arrangements for the Washington meeting are being rapidly perfected under the energetic direction of Wm. R. King, M.D., Chairman of the Local Committee. According to latest information from headquarters, on Saturday, June 16th, at 3 P.M., the first meeting of the American Homœopathic Ophthalmological, Otological and Laryngological Society of the A. I. H. will assemble at the Hotel Shoreham, with a second session at 8 P.M. at the same place. On Monday, the 18th, two extra sessions will be held, at 9.30 A.M. and 2.30 P.M., the final session being on Tuesday, the 19th inst., at 9.30 A.M. On Monday, the 18th, at 2 P.M., the first session of the New Surgical and Gynæcological Society of the A. I. H., Dr. Wm. B. Van Lennep, President, will convene at the Arlington Hotel, with an evening session at 8 o'clock. The same society will hold meetings on Tuesday, the 19th, at 9.30 A.M. and 2 P.M., at the same hotel. This society has a large programme of exceptional merit, with some seventy papers. We have not seen or heard anything of the American Institute Sections of Surgery and Gynæcology, nor do we know who the chairmen are, but it will take work of a high order to secure a programme to offset the new society, and we trust the chairmen will measure up to the responsibility of their positions. The Institute will not be in humor to entertain "the new society" as an excuse for any shortcomings.

THE AMERICAN INSTITUTE will convene *Tuesday*, June 19, 1900, at 3.30 P.M., at the Arlington Hotel, with a short business session. The formal opening will be held at the New National Theatre, at 8 P.M., with music by Military Band, the President's Annual Address and short speeches by public men, winding up with an informal reception on the stage of the theatre by President Charles E. Walton, of Cincinnati, Ohio.

Wednesday, June 20th.—Business meeting at the Arlington morning and afternoon, with sectional meetings for scientific work at the Arlington and Shoreham. *Wednesday* night, June 20th, 8 P.M., a special meeting to commemorate the completion of the monument, under the auspices of the Hahne-mann Monument Committee, at the Arlington Hotel.

Thursday, June 21st, A.M.—Business and sectional meetings, and the election of officers for the ensuing year and the determination of the next place for the meeting of the Institute.

At 1 P.M., reception to the members and visitors of the American Institute of Homœopathy, at the “White House,” by the President of the United States.

At 5 P.M., at “Scott Circle,” at the intersection of Massachusetts and Rhode Island Avenues, the formal dedication of the Hahnemann Monument. The entire U. S. Marine Band will be in attendance. The monument will be presented to the Institute by the Chairman of the Monument Committee, James H. McClelland, M.D. Being unveiled at this time, the monument will be received for the Institute by President Charles E. Walton, M. D. This will be followed by the Presentation of the Monument by President Walton, in behalf of the American Institute of Homœopathy, to the United States, through President McKinley or his representative.

William Todd Helmuth, M.D., New York, will deliver an “Ode to Hahnemann,” and short speeches will be made by several prominent public men, interspersed with music by the Marine Band.

Thursday evening is left open for personal enjoyment. Many small minglings are already arranged.

Friday, June 22d.—Business and sectional meetings all day.

Saturday, June 23d.—Business and sectional meetings in the morning. At 3.30 P.M. the Washingtonians have arranged for a unique jaunt up the Potomac—viewing the Potomac Palisades and other attractions, ending with a rare entertainment and a general wind-up.

With a promise of good weather and a scientific programme satisfying to the most exacting, the outlook for the last American Institute meeting of the century is brilliant, indeed. The attendance will be the largest in the fifty-six years of the life of the Institute.

Each member of the Institute, whether able to be present or not, should make a special effort in the way of a *liberal* contribution to wipe out the last dollar due on the monument, which now stands finished in the most attractive site in Washington—a pile of artistic elegance second to nothing in America, reared by loving hearts and hands as a memorial of Hahnemann and his work.

GLEANINGS.

A VOLUMINOUS ANEURISM OF THE ABDOMINAL AORTA CURED BY GELATINE INTERNALLY.—Dr. J. Buchholz reports the interesting case of a woman of 35 years, a mother of seven children, the last just weaned, who, beyond the influenza and a few children's diseases, had always been in good health. But since Christmas, 1898, after having lifted a heavy sack, she had become very weak and emaciated, had little appetite, "there was gradually less and less place for food" in her stomach; vomiting, violent attacks of pain, especially in the region of the stomach; distention of the region of the diaphragm, meteorism, constipation and insomnia. The aneurism was oblong, smooth, yielding to pressure, with thin walls, pulsating and larger than one's fist. The souffle was simple and systolic; the heart was not disturbed; the heart-sounds normal; the pulse feeble. As circumstances would not permit hypodermatic injection of a solution of gelatine, he administered it *per os*, and applied an ice-bag locally for fear of rupture. The patient was kept in bed; a 10 per cent. solution of gelatine was dissolved in a physiological solution of sea-salt for two days; later it was taken dissolved in ordinary water. In twenty days she was seen again. General amelioration from the first day. The pains had almost ceased, the sleep and appetite were normal, and "there is place for food;" the aneurism was reduced to half its former size; still a little meteorism; the bruit de souffle wholly disappeared. Treatment continued. A month later she reported her strength gaining daily. A month still later her condition was wholly satisfactory; the tumor reduced to a soft node; like a "joint" on a lead pipe. The gelatine was continued for four weeks later; she was allowed to take up her work, little by little. Though not attributing the success wholly to the gelatine, for ice has been employed, notably in France, in treating aneurisms, yet physiologists agree that, administered hypodermatically, gelatine augments the coagulating power of the blood; it would be worthy of trial to see if, given by the mouth, it does the same. It is at least easier to administer thus.—*Norsk Magazin for Lægevidenskaben*, No. 2, 1900.—(The *Semaine Medicale* of 1898 and 1899 contains much literature on Lancereaux's method of treating aneurisms by gelatine.)

Frank H. Pritchard, M.D.

TREATMENT OF CARDIO-SCLEROSIS.—Dr. H. Huchard, of Paris, the well-known authority on heart diseases, divides the disease into three stages, as to treatment—arterial, cardio-arterial and mitro-arterial.

Treatment of the arterial stage, presclerotic, or stage of hypertension. Hygiene and diet are of capital importance; milk foods and milk; suppression of certain drinks which are exciting, as tea, coffee, liqueurs and pure wine; of foods containing more or less ptomaines, as fish, "high" or raw meats, conserves, cheeses, pork in various forms, and game which is the more toxic the more that the animal is chased. Reduce the quantity of beverages; for,

except that they be diuretic, the more taken into the system the greater will be the arterial tension. Excessive use of meat is particularly harmful, for alimentary toxins are vaso-constrictive *to a high degree*. Mineral waters twice a day, with 0.50 of lyceol, are of service. Great meat-eaters have usually high tension pulses; hence the quality of the diet is of greater importance than its quantity. An excellent means of counteracting high tension is by gymnastics, general and abdominal massage. The latter reduces the stasis in the mesenteric veins and increases diuresis. The abdominal plethora of the older writers should be rehabilitated, for in certain subjects with slow nutrition, as arthritics, "uricemics," obese and diabetic subjects, this stasis of circulation is a powerful cause of arterial hypertension, either temporary or permanent, and because those diseases due to a retardation of nutrition commence by a slowing of this circulation, which retains and stores up the toxins. In these cases abdominal massage appears to increase the flow of urine like digitalis.

Diuretic treatment is of great importance. Milk diet, at least a quart of milk daily, with many vegetables, and but little or no meat, is useful. Digitalis should never be employed here. Lactose is uncertain; calomel is unreliable and difficult to manage—at times even dangerous. The nitrate and the acetate of potash are also better not employed. For several years he has used the extract of *betula alba*, six to eight pills of 20 cgm. a day. This is a wholly inoffensive medicine, causing at most only a little colic. Urea is wholly unreliable. Caffeine, and more particularly theobromine, are the most powerful and reliable diuretics known. It should not be administered in too large a dose, as it may cause albuminuria. He warns strongly against an abuse of medicine during this stage, and *particularly of the iodides*. Hygiene and diet are quite sufficient.

Treatment of the cardio-arterial period:—Continue the hygienic and dietetic regulations, and give methodically trinitrine, three drops a day of a 1:100 sol. of the alcoholic solution, and the remaining twenty days of the month ten 0.20–0.50 of the iodide of sodium. Beware of too large doses of the iodide, particularly of the potassic salt, as it may fatigue the heart and bring about an actual "asystolic iodique." At the end of the period leave these drugs off from time to time and administer digitalis or sparteine.

Treatment of the mitro-arterial period:—This is that of a badly compensated mitral disease, with associated toxic symptoms. Hence give theobromine, 1.50–2.0, three or four times a day, with digitalis or digitalin, with a *rigid milk diet*.—*Journal des Praticiens*, No. 51, 1899.

Frank H. Pritchard, M.D.

CLINICAL SIGNS OF PEPTIC ULCER OF THE DUODENUM.—Dr. Burwinkell has observed five such cases with a common cause, for all the patients were forced by their occupation to be much in a bent position; in four there was tuberculosis in the family. Diagnostically, the chief signs are:

1. *Melæna*: A tar-like appearance of the stools; syncopal collapse with loss of blood, yet without vomiting of blood. (*Hæmatemesis* is noted in 8 per cent. of duodenal, in 30–50 per cent. of gastric ulcers.)

2. Seat and appearance of the pains: In the right hypochondrium, or in the umbilical region, with a painful point to the right or the left of the navel. In two cases the pains, which had been very severe, ceased after hæmorrhage.

3. The preceding dyspeptic symptoms, disturbances of nutrition, rarely

icterus, and then when the ulcer is situated at the opening of the ductus choledochus.

4. The sex and age of the patients: Men in the best years of life.—*Deutsche Medicinische Wochenschrift*, No. 52, 1899.

Frank H. Pritchard, M.D.

THE DIFFERENTIATION OF RHEUMATISM FROM RHEUMATOID ARTHRITIS AND GOUT.—Tuff (*Edinburgh Medical Journal*, March, 1900) insists that rheumatism may be distinguished from rheumatoid arthritis and gout by the following points: Rheumatism yields to salicylate of soda, rheumatoid arthritis and gout do not; rheumatism is associated with erythema and disease of the heart; it does not produce permanent deformity of the joints, with long out-growths and lipping of the cartilages; it oftentimes flies about from joint to joint. Gout and rheumatic arthritis he separates from each other by noting that rheumatoid arthritis occurs most frequently in females, gout in males; the former is most common among the ill-nourished, gout among the well-nourished; rheumatoid arthritis is improved by good diet, gout requires a spare diet; the onset of the former is insidious, the latter sudden; gout is associated from the beginning with severe pain, and in rheumatoid arthritis the pain is usually of gradually increasing severity. Gout practically never attacks the temporo-maxillary articulation. Rheumatoid arthritis is remarkably symmetrical, while gout is not.

Tuff considers rheumatism an infectious disease due to accumulation of uric acid in the blood from some obscure cause; he believes that rheumatoid arthritis is infectious because it is often a sequel to infectious disease, and because micro-organisms have been several times found in the disease, and recently a diplococcus has been discovered which produced a similar disease in rabbits. Against the possibility of its being nervous he puts the facts that the muscular wasting is due to mere disuse, and is not associated with the reactions of degeneration, and no nerve-lesions are regularly discovered.—*Phila. Med. Journal*, April 28, 1900.

F. Mortimer Lawrence, M.D.

THE EFFICIENCY OF ANTITOXIC SERUMS.—Cabot classifies the serums according to efficiency as follows:

I. Markedly curative—Anti-diphtheritic serum; anti-spirillum serum (re-lapsing fever).

II. Efficient as protective—Anti-cholera serum; anti-plague serum.

III. Limited utility in selected cases—Anti-tetanus serum; Koch's tuberculin (strictly a toxin, not an antitoxin).

IV. Doubtful but hopeful—Anti-typhoid serum; anti-dysenteric serum.

V. Probably inert—Anti-streptococcus serum; anti-pneumococcus serum; anti-amarillic serum (yellow fever).

Under a slightly different heading comes the treatment of inoperable cases of malignant disease by the injection of the toxin of erysipelas, which appears to have a distinct though very limited field of usefulness.—*Phila. Med. Journal*, May 5, 1900.

F. Mortimer Lawrence, M.D.

THE PHYSICAL SIGNS OF PULMONARY DISEASE.—Pye Smith (*Lancet*, April 7, 1900) condemns the usual method of naming the physical signs of pulmonary disease elaborately. He states, with great emphasis, that the physical signs elicited over the chest tell only of the perversion of function, and

not of the nature of the pathologic process. He therefore objects to speaking of "pneumonic" crepitation and "bronchitic" *râles*, and the like. The differences in percussion-notes are differences in the degrees of length, intensity, pitch and tone of the note. There is no note that is peculiar to any one disease. The differences on auscultation are likewise not distinctive of definite pathologic changes. The custom of speaking of dry and moist *râles* is not a happy one, as he does not believe in such a thing as a dry *râle* with free expectoration. The most important character of *râles* is as to whether they are consonant or non-consonant; that is, whether they have any musical quality or are mere noises. The consonant *râles*, in his experience, always mean pneumonic-consolidation. The term "capillary bronchitis" is an inadvisable one, as the condition which this is used to describe is really a lobular pneumonia. He also insists that we usually look for too pronounced signs in the very early stages of phthisis, and if we check our auscultation and percussion by our knowledge of pathology we cannot expect any notable signs. The cause of marked dullness at the apex is more often pleural thickening on the large cavity rather than extensive consolidation of the lung.—*Phila. Med. Journal*, April 28, 1900.

F. Mortimer Lawrence, M.D.

BACTERIOLOGICAL TESTS IN MEDICINE.—According to Cabot, of Boston, so far only two, or possibly three, bacteriological tests can be said to be in general use throughout this country, viz.:

1. The search for the tubercle-bacillus in sputa.
2. The search for the diphtheria bacillus in the throat, and, possibly,
3. The agglutination test for typhoid.

Other such aids to diagnosis which seem likely to come into more general use are the examination of:

a. The Blood—(blood-cultures in pyæmia, malignant endocarditis, bubonic plague, pneumonia, gonorrhœal septicæmia).

b. The Sputa—for the influenza bacillus, plague-bacillus, and micrococcus lanceolatus.

c. The Urine—for the bacilli of typhoid and tuberculosis.

d. The Fæces—for the bacilli of typhoid, tuberculosis and cholera.

e. Cerebro-spinal Fluid—for the diplococcus intracellularis, tubercle bacillus, and micrococcus lanceolatus.

f. The urethral, vaginal and uterine secretions—for gonococci.

g. The nasal, pharyngeal and conjunctival secretions—(for influenza or diphtheria-bacilli, bacillus of Friedlander, bacillus of Weeks).

h. Pleuritic or pericardial effusions for pneumococci, streptococci, etc.—*Phila. Med. Journal*, May 5, 1900.

F. Mortimer Lawrence, M.D.

THE TECHNIQUE OF LUMBAR PUNCTURE. (Conner, New York.)—In discussing the choice of location at which the puncture shall be made there are three requirements to be considered:

1. That the needle shall find ready entrance to the subarachnoid space.
2. That the tapping be made at the point least likely to admit of damage to the nervous structures of the canal.
3. That the fluid obtained shall be as rich as possible in sediment.

If the puncture be made for purposes of diagnosis, then it seems best to enter the lumbo-sacral space, and to have the patient, if a child, in a sitting

position. In adults it is better to operate while the patient lies in a horizontal position on the side.

Just such perfect asepsis, as to field of operation, instruments and hands, is demanded as would be exercised by the surgeon in opening any serous cavity.

After the desired space is located, the interval between the spines is marked with the finger of the left hand, and the needle is introduced at a point opposite the upper edge of the lower spinous process, and in a line just outside, *i.e.*, a few millimeters from the median line.

The needle is directed VERY slightly upward and toward the median line, with a view to having it in the median line when it enters the subarachnoid space.

In children the fluid is reached at a depth of from two to three centimetres; in adults, at from four to seven.—*New York Medical Journal*.

Herbert P. Leopold, M.D.

A REMARKABLE CASE OF SUPERFETATION. (Nicholson, Salem, N. C.)—Mrs. J., aged 41, multipara. Found patient suffering greatly with severe pains, in nowise expulsive. Examination revealed abnormal state of affairs. The os partly dilated, the waters had escaped, and he found he had to deal with a transverse presentation. After several hours true labor-pains came on, and with some difficulty he removed a fœtus apparently three months old. It was seemingly healthy. About eight hours later, after an entirely normal labor, his patient gave birth to well-developed living child, weighing eleven pounds. Superfœtation, or the possibility of impregnating a female already pregnant, is generally denied. In this instance we have an apparent impregnation after six months.—*Charlotte Medical Journal*.

Herbert P. Leopold, M.D.

ANASTOMOSING APPENDIX. (Wenner, Cleveland.)—There was a mass the size of an orange in the classic region. On opening the abdomen there was found a heavy exudate around the coil of the appendix, which was long and opened into the large intestines at both ends. Microscopic examination showed this condition to be congenital. Beginning about one and a half inches above the region of the appendix, and extending upwards about four inches, there was a marked thickening of the large intestine, causing it to feel like a large bologna. There were a number of running tubercles on the outside, which, however, proved to be lymph-nodes. The distance from the outside of this enlargement to the centre of the intestine was at least an inch. The administration of iodide of potassium partially caused its disappearance, as the condition was probably luetic. The man made a nice recovery.—*Cleveland Journal of Medicine*.

Herbert P. Leopold, M.D.

SHOCK AND ITS SURGICAL SIGNIFICANCE.—Rishmiller (Minneapolis) lays great stress on the prophylaxis of shock. He is in the habit of giving his patients an ounce of "good brandy" by the mouth, one hour before starting to operate. This is followed up by a hypodermic injection of sulphate of morphine, a quarter or a sixth of a grain, administered just prior to the starting of the anæsthetic. He avoids hypercatharsis, giving, instead, a mild saline laxative. In major operations, or where the patient's vitality is in any degree below normal, a pint of normal saline solution with two ounces of brandy

is injected, just before operating, well up into the sigmoid flexure. The operating-room is kept warm, and the patient well covered and *dry*. "The vigorous rubbing of one extremity and then another is a marvelous means of combating initiatory shock." In the treatment of shock, the writer cautions against a too great energy, stating that many cases of shock are stimulated to death.

Among the drugs recommended are camphor 1.0; oil of sweet almonds 5.0—administered hypodermically, 30 minims every hour "*pro re nata*." Natrum caffeine, strychnine sulphate, morphine, and nitroglycerine are also advised, and for hæmorrhage, infusion of normal saline solution. The author draws the following conclusions:

1. Sensory-nerve irritation sufficiently powerful to produce exhaustion of the vasomotor centre causes a reflex paralysis, and consequently a dilatation of the vascular mechanism.

2. Children and aged people with lax fibres and those addicted to alcohol bear a peculiar susceptibility to shock.

3. Hæmorrhage is the most pronounced cause, particularly if venous, as then the equilibrium of the vasomotor mechanism is too suddenly deranged.

4. Two distinct types are recognized: prostration with indifference, and prostration with excitement.

5. Peritoneal absorption of septic material invariably terminates fatally through shock before evident manifestations of peritonitis have developed.

6. A subnormal temperature, irregular pulse, superficial respiration, cold and anæmic extremities, and clammy perspiration contra-indicate an operation.

7. The severity of operative shock largely depends upon the length of time in the performance of the operation and the duration and degree of the anæsthesia.

8. Shock may to a large degree be prevented by any counter-irritation applied to the extremities.

9. Brandy *per os* and morphine subcutaneously before operating are imperative precautions toward prophylaxis.

10. The main treatment consists in stimulating the vascular system, and in preserving the animal heat and supplying artificial heat to the body.

11. In acute hæmorrhage, or other excessive anæmia, an infusion of normal saline solution is prudently indicated.—*The New York Medical Journal*, March, 1900.

Gustave A. Van Lennép, M.D.

EXTRA-UTERINE PREGNANCY, OPERATION. VENTRAL HERNIA, OPERATION. NORMAL PREGNANCY AND LABOR.—Russell S. Fowler, M.D., New York City, reports the following case: The patient was admitted to the Brooklyn Hospital, March 20, 1896. A diagnosis of ruptured right tubal pregnancy was made.

Operation.—By Dr. George R. Fowler. A four-inch incision was made above the pubes and carried into the peritoneal cavity. There was an immediate gush of blood and clots. The hand of the operator rapidly grasped the right tube and thus stopped any further hæmorrhage. While this tube and ovary were being ligated and removed, five pints of normal salt solution at a temperature of 120° F. were infused into the left median cephalic vein, which had been opened preliminarily for this purpose. The peritoneal

cavity was sponged free of blood and fluid amounting to several quarts. The cavity was flooded with hot solution and left filled with it. The incision was closed with crossed silkworm-gut sutures except for the lowermost angle, through which a gauze drain was placed against the stump of the excised tube and ovary. The subcuticular suture originally devised by Kendal Franks was employed in closing the incision. Abundant gauze dressings were applied.

There was some infection of the wound, which delayed final wound-healing. At the time of discharge there was no hernia, nor was there any perceptible difference in the feel on coughing at this point from other parts of the abdominal surface.

The case was lost track of until February 14, 1898, two years after the extra-uterine pregnancy. She had been well for one year following her discharge from the hospital. One year ago she noted a small swelling at lower end of the laparotomy scar. This had progressively grown larger until a tumor the size of her head was present.

Upon operation this was found to contain the uterus, left ovary and tube, the bladder, several feet of small intestine, and a portion of the omentum. The wound was closed as follows, the method being devised by Dr. G. R. Fowler:

"The suture consists of a strand of silkworm-gut with a needle threaded on either end. In order to secure the needle firmly to the thread the latter is passed through the eye of the needle a second time, and from the same direction as the first, the resulting loop being then drawn taut.

"Each needle is passed through the peritoneum near the edges of the wound in the manner of a Lembert suture, so as to approximate surfaces of the peritoneum rather than the edges. The ends are then crossed to opposite sides of the wound and passed through the muscular and fascial layers. Again the ends are reversed and passed through the skin. In this manner the peritoneum is first secured, then the muscular layers, and finally the skin in turn. The crossed sutures are tied in pairs on either side of the wound. In order to guard against cutting of the skin from the silkworm-gut, the sutures are tied over 'bolsters' of sterile or iodoform gauze, or, what we find exceedingly convenient for this purpose, they are passed through sections of thick-walled tubing of soft rubber (aspirator tubing). Upon 'setting' the sutures in position the ends of each pair of the latter are tied over the corresponding bolster in turn, and the skin edges of the abdominal wound approximated by the subcuticular suture known as the Kendal Franks, or Marcy, suture.

"Removal is accomplished by cutting the sutures beneath the bolster on one side and making traction upon the other end of the thread."

The case made an uninterrupted recovery. The cross-sutures were removed on the eighteenth day. Two weeks later she left the hospital, one month following the operation.

The case again passed from under observation until April 6, 1899, one year and two months since the last operation, when she was admitted to the Maternity. She was pregnant and at term. The labor was a normal one, with a somewhat prolonged first stage. When discharged from the Maternity the condition of the abdominal scar was perfect.—*Brooklyn Medical Journal*, March, 1900.

THE EARLY DIAGNOSIS OF UTERINE CANCER. (Wiener.)—The early diagnosis of malignant disease of the uterus is one of the most difficult and responsible the physician is called upon to make. Each error in diagnosis costs a human life; each delay endangers one. There are no symptoms pathognomonic of cancer of the uterus. Pain, hæmorrhage and discharge have been considered such, but if we wait for the symptoms to appear the case is almost entirely hopeless. Pain is usually a late symptom, and the least valuable of all. Discharge is often present with uterine cancer, but in the early stages is not due to the new growth, but to the pre-existing endometritis. Hæmorrhage is the most valuable symptom, but as it is symptomatic of other conditions it can only serve to rouse our suspicions. Hæmorrhage from the uterus, either as menorrhagia or as metrorrhagia, no matter at what time of life, should be looked upon with suspicion, and especially at the menopause. The belief that uterine laceration predisposes to cancer is not generally held to-day. No age is exempt from this disease. It frequently develops from chronic inflammation of the endometrium. Thorough curetting of the entire uterine cavity is the surest means of making a diagnosis with the aid of the microscope. We may find only a small place in the endometrium showing the presence of malignant disease, and scrapings from the remainder of the uterine cavity will show normal tissue only. Dilatation of the cervical canal is generally necessary, and a sharp curette must be used *always*. Not the slightest reliance can be placed on the examination of scrapings removed with a dull curette. Frequently what is thought to be clinically a case of ordinary endometritis turns out to be a beginning of malignant growth.—*The American Journal of Obstetrics*.

George R. Southwick, M.D.

TREATMENT OF THE UMBILICAL CORD. (Ahlfeld.)—The writer reports that the following method has been used in the Marburg Lying-in Hospital in much more than a thousand consecutive cases with the best of results in every case. The cord is cut quite short, and thoroughly wiped, together with the adjoining skin, with 96 per cent. alcohol. It is covered with sterile cotton and is not changed for five or six days unless wet with urine. The cord is first cut four or five inches from the navel, and about an hour and a half after the child is bathed, and the cord has somewhat collapsed, a ligature is applied half an inch from the navel, and the cord cut again half an inch beyond this, when it is dressed as above.—*Centralblatt für Gynäkologie*, No. 13, 1900.

A SIGN OF THREATENING ASPHYXIA IN CHLOROFORM NARCOSIS. (Koblanck.)—The writer calls attention to the great importance of athetotic movements of the fingers as a sign of danger. They occur only in complete extinguishment of the reflexes, and, when it occurs, it is one of first signs of danger. The pulse and respiration may be undisturbed, and the pupils contracted without reaction, but if more chloroform is given, the usual signs of asphyxia appear. In case of asphyxia, too great importance cannot be given to the direct drawing forward of the epiglottis with the finger. The lifting forward of the lower jaw and traction of the tongue with forceps cannot be relied on to make free the entrance of the trachea.—*Centralblatt für Gynäkologie*, No. 1, 1900.

George R. Southwick, M.D.

AMBLYOPIA FROM HÆMORRHAGE.—Holden has experimentally investigated the blindness observed after profuse hæmorrhage, which has been accounted for variously. He operated on two healthy dogs, and later examined the eyes microscopically. The pathologic conditions were œdema of the nerve-fibres and ganglionic-cell layers of the retina, and some ganglion-cells beginning to show signs of degeneration. This will explain the ordinary cases of amblyopia following hæmorrhage. In those unusual ones in which the sight-disturbance takes the form of a central scotoma, while the ophthalmoscopic changes indicate retrobulbar neuritis, some special explanation is required which cannot be given except after pathologic investigation of each peculiar case. He also investigated the suddenly developing amblyopia which has been observed after injection of methyl alcohol, and finds that it comes under the same category, as due to the nutritive disturbance in the ganglion-cells of the retina.—*Archives of Ophthalmology*.

William Spencer, M.D.

ALOIN AS A LOCAL ANÆSTHETIC IN SUBCONJUNCTIVAL INJECTIONS.—Carter has used aloin solution 1 to 100 by subconjunctival injection to produce local anæsthesia in ophthalmic practice, and finds it a non-poisonous local anæsthetic of very prolonged action. It is also strongly antiseptic and keeps well in the dark. It is believed that its use will greatly facilitate the treatment of some of the more intractable inflammatory affections of the eye.—Robert Brudenell Carter, *The Philadelphia Medical Journal*.

William Spencer, M.D.

THE SPECIFIC GRAVITY OF THE AQUEOUS HUMOR.—Golowin has recently made a number of experiments to determine the specific gravity of the aqueous humor. His experiments were made with a great deal of care and ingenuity. It is not necessary to go over them in detail, but these are his conclusions, or rather his results: He found that the normal specific gravity of the aqueous of the animals used in his experiments was about the same; that is, 1.008.

The aqueous humor which was re-formed after emptying the anterior chamber was found to have a much higher gravity than the normal, but in twenty-four hours the specific gravity of the re-formed aqueous had returned to the normal. It will be remembered that other investigators have called attention to the fact that the fluid which re-formed in the anterior chamber after a paracentesis was not identical in all respects with the normal aqueous, but resembled more in its properties a serous transudation. It was found by Golowin that the osmosis of a five-per-cent. salt solution from the conjunctival sac produced practically no change in the specific gravity of the aqueous humor, but when the corneal epithelium was removed it was noted that the specific gravity of the aqueous had gone up. When a five-per-cent. salt solution was injected beneath the conjunctiva there was no appreciable change in the specific gravity of the aqueous. Immediately after the death of the animal the specific gravity went down.

The author tested the specific gravity of the aqueous humor in three cases of glaucoma, and he found that there was no deviation from the normal so long as there were no changes in the anterior chamber, while in acute glaucoma the specific gravity of the aqueous was markedly higher.—Dr. S. S. Golowin, of Moscow (*Archiv. für Ophthalmologie*).

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

POISONING BY ŒNANTHE CROCATA.—Dr. Griffin, Assistant Medical Officer to the Killarney District Lunatic Asylum, records in the *British Medical Journal* (March 3, 1900) two cases of poisoning by *œnanthe crocata*. The victims, working together in a field, ate of what appeared to be a carrot. Each was soon after seized with a fit, even the experienced superintendent in one case regarding it as epileptic. One patient had in all eight convulsions, chronic in character and general in distribution, but attaining their greatest intensity in the lower extremities first, next in the upper extremities, and finally in the facial muscles. He died before a hypodermic of apomorphine had time to act. The second patient had a fit, followed by vomiting while being carried to the ward. Emesis was kept up by giving ipecac and tepid water, and the patient did not lose consciousness. A marked change in mental state followed the convulsion, however. The patient was delirious, talked incessantly to himself, was drowsy, and did not like being questioned.

The *Monthly Homœopathic Review* (April 2, 1900) regards these cases as interesting, as giving evidence of the extreme similarity (or, rather, identity) of the symptoms with those of epilepsy. Occurring in an asylum, where the phenomena of epilepsy are only too commonly observed, experienced observers were not led to suspect any toxic origin for them. In the record of six post-mortem examinations of fatal poisoning by *œnanthe* (*Cyclopædia of Drug Pathogenesis*, vol. iii., p. 457), we fixed that the veins of the pia were greatly distended; in one case there was found beneath it sufficient blood to cover both hemispheres. The cerebral substance, especially the white matter, was strongly injected, as was also the medulla oblongata: the cerebro-spinal fluid was abundant. The intensely irritant local effect of the root of water-parsnip upon fauces and œsophagus, which was experienced by the second of Dr. Griffin's patients, is also in evidence. In the experiments on animals (*in loc. cit.*) it is seen that this irritation is capable of setting up acute peritonitis, and even necrosis of the colon. A careful series of provings would probably manifest *œnanthe* as a powerful polychrest.

F. Mortimer Lawrence, M.D.

THE DIGESTIVE SYMPTOMS OF LYCOPODIUM.—According to Spaulding, of Los Angeles, Cal., the lycopodium patient is, as a rule, constipated, with no desire for stool. Especially is this true in old people. There is also ineffectual urging to stool; it is almost impossible to evacuate the bowels. Notice the similarity to *nux*; but *nux* has frequent calls recurring at intervals, while lycopodium has this constant, ineffectual urging, with more or less rumbling of gas. The digestive tract is peculiarly affected. There is always an excessive accumulation of gas; the tongue is coated; there is a sour or bitter

taste in the morning, maybe sour vomiting. There is great hunger, and yet he is unable to eat because he is so "full;" and if he tries, a few mouthfuls satisfy and cause a sensation of fullness clear up to the throat; but the hunger soon returns, and when he can eat, there is distress in the stomach immediately following the eating—not some time after, as in nux. He cannot bear the touch of the clothing about the waist. Notice the similarity to lachesis; but lachesis has this sensitiveness all the time, not especially after eating. The accumulation of gas in the stomach may account for the small quantity of food filling the patient up, the constant feeling of satiety, and yet the sensation of hunger. The gas seems to press upward more than downward. In nux, the pressure is more downward, with pressure on the bladder as if from a sharp instrument. There is great accumulation of gas in the abdomen, with much rumbling of flatus, and cutting pains from right to left, with distention of the transverse colon. The pressure in the abdomen may be so severe as to prevent standing erect. The pressure upward may cause dyspnoea. There is another symptom, like a pot of yeast working. There may be diarrhoea with this, and if so, the stool is pale, thin, and mixed with small, hard lumps.—*Pac. Coast Jour. of Hom.*, April, 1900.

F. Mortimer Lawrence, M.D.

THE ACTION OF CEANOTHUS.—Fahnestock, of Piqua, Ohio, relates the case of a patient who came to him complaining of an "ague cake" (splenitis). Many remedies had given only partial relief. The spleen was much enlarged and painful on pressure. The patient was unable to lie on the affected side. The face was pale, she was thin, her appetite was poor, the tongue was coated a dirty white, and there was general weakness. Ceanothus cured the case in a few months, and he has given the remedy in a number of similar cases with equally happy results.

Recently he made three provings of ceanothus. In each prover the spleen was acted upon first, then the liver and bowels. The drug produces a splenitis with enlargement. There is a deep sticking pain in the spleen, worse by motion, but at the same time the prover is unable to lie on the affected side. There is a like enlargement of the liver, with sticking pains, the patient in consequence being unable to lie on either side but for a short time, and constantly rolling from side to side.

In every prover the urine had a distinct greenish color, was frothy, contained bile, and was alkaline in reaction. In one prover quite a quantity of sugar appeared in the urine. One prover lost four pounds in weight, and the face became pale, with general exhaustion.

Ceanothus would therefore appear to be indicated in anæmias where the liver and spleen are involved.—*Med. Era*, April 15, 1900.

F. Mortimer Lawrence, M.D.

THE ACTION OF HYPERICUM PERFORATUM.—At the recent session of the British Homœopathic Society Dr. J. R. P. Lambert read a paper entitled "A Study of Hypericum Perforatum," in which he gave a short history of the uses of the drug, the sources of our present knowledge, a survey of the sphere of its action, a detailed account of the organs and systems in which its effects are manifested, and, finally, an account of the clinical uses of the drug from the homœopathic point of view. "The nervous system is most prominently affected, and here," as Dr Pope says, "the drug induces a state of

general hyperesthesia, and in some cases an hysterical condition." It deranges the digestive functions, and has an important action on the rectum. It also affects the urinary and female genital organs, and produces a number of respiratory and a great many circulatory symptoms. Lastly, it has a definite action upon the skin. The clinical uses of the drug in diseases of the nervous system—its more important sphere—are: in facial spasm, tetanus (?), epilepsy of traumatic origin, spinal-cord lesions of traumatic origin, neuralgia from a similar cause, and also in neuritis."—*Monthly Hom. Review*, April 2, 1900.

F. Mortimer Lawrence, M.D.

THE USE OF CONVALLARIA IN HEART DISEASES.—According to the *Eclectic Medical Journal*, in the convallaria case there is heart discomfort; there is fluttering and palpitation; a sudden stop, then a sudden start, that makes the patient faint and nauseated. The symptoms are aggravated by ascending stairs or by active exercise. There may be organic heart trouble or there may not be. The pulse is usually softer than common. In the so-called "tobacco heart" and in "bicycle heart" convallaria has no equal. It is a safer and better remedy in organic heart troubles than is digitalis. It is a more powerful remedy in all conditions than is cactus. Its effects in mitral stenosis or insufficiency, or aortic regurgitation, are as beneficial as can reasonably be expected from any drug. Through its tonic effect upon the heart and consequent diuretic effects, it frequently dissipates a dropsy due to mitral trouble. It lessens the pulse and augments the force of contraction. In the same way a hydrothorax, a pulmonary stasis, the dyspnoea, palpitation and distress of the later stages of phthisis pulmonalis, may be mitigated by convallaria.—*The Critique*, April 15, 1900.

F. Mortimer Lawrence, M.D.

NITRIC ACID AND ITS ACTION ON THE KIDNEYS.—Dr. Piedvache calls attention to the strong odor of the urine when nitric acid is indicated (acid. benz.). This remedy resembles cantharis in action on the kidneys, for there is tenesmus vesicæ, albuminuria, violent pains in the urethra, bloody and purulent urethral discharge; whence it may be used with success in the acute stage of gonorrhœa (cann.), in acute cystitis with frequent micturition, hypogastric pain, hæmaturia, in albuminuria and Bright's disease, when there is great distress in the region of the kidneys, the urine being scanty and the breath fetid. On the contrary, polyuria has been noticed (interstitial nephritis).—*Revue Homœopathique Française*, No. 3, 1900.

Frank H. Pritchard, M.D.

TREATMENT OF HÆMOPTYSIS.—In the *Homœopatisk Tidskrift*, No. 2, 1900, in the treatment of hæmoptysis, the following remedies are recommended:

Aconite.—When the patient has been exposed to dry, cold air. He is full-blooded, inclined to palpitation of the heart, burning and stitching pains in the chest, red cheeks, tense and hard pulse, quite a degree of restlessness, anxiety and fear of death. When the nervous symptoms are prominent: aconite. When the heart and pulse symptoms are most pronounced: veratrum vir.

Hamamelis Virginica.—This drug is of service when the expectorated blood is dark; at the same time there are varicose nodes on the legs and associated painful and bleeding hæmorrhoids.

Ipecacuanha.—Useful in great weakness, with aversion for food and long-lasting nausea; expectoration of light-red blood at the least exertion.

Phosphorus.—Indicated in great weakness in spindling and tall individuals, with a feeling of hollowness in the whole abdomen. A sense of contraction across the thorax, with a desire to walk bent over. The bleeding is profuse, ceases, and then commences again.

Ferrum.—Here the pale face, which at times flushes up again, is characteristic. The stools are undigested; the feet and legs become œdematous. The hæmoptysis is ameliorated by walking slowly about.

Millefolium.—Of service in spitting of blood from cavities in the lungs; from pulmonary tuberculosis. The blood is very profuse—light-red, as with aconite, but with the last-mentioned remedy there are fever, restlessness and deathly anguish.

Geranium Muculatum.—Doses of 10–20 drops of the tincture every half hour aids in the hæmoptysis of the last stage of tuberculosis, when homœopathic and other measures fail.

Arnica Montana.—When the bleeding is caused by a blow, injury, or a traumatism of some kind. The face is hot, with cold body and limbs. The patient is weak and complains of pains in the muscles.

Belladonna.—In strong and full-blooded persons, where the blood suddenly is coughed up and is worse towards night. The blood is light-red; there is palpitation of the heart and throbbing headache, with aggravation on movement.

Pulsatilla and *Crocus* are good remedies where the hæmoptysis is a vicarious menstruation.

Sulphur is of value in cases which are nearly cured but recur.

China is indicated in great anæmia following loss of blood, when the weakness is most striking. The abdomen is distended without relief from eructations or an evacuation of the bowels. It is also indicated in sour eructations with a watery diarrhœa, worse at night and profuse night sweats.

Frank H. Pritchard, M.D.

INFLUENZA AND ITS TREATMENT.—Dr. Clarke, in the epidemic of the gripe of this year, has found *baptisia tinctoria* to be the most prominent epidemic remedy. The dull, heavy and sleepy state, with general prostration, restlessness, feverishness with dry tongue, are indicative. He frequently repeats the remedy. It acts well in all dilutions.

If the catarrhal symptoms prevail, with severe coryza, sneezing and laryngeal cough, he administers *allium cepa*. In one case there was a painful sensation of threads running up through the fingers and in other parts of the body.

Sanguinaria is an excellent remedy when the trachea is attacked and the cough violently irritating, the sputa difficult to raise and scanty. With pain in the right side, it is the better indicated. After this remedy *chelidonium* is to be thought of, which it closely resembles in its action.

Another remedy, which was often of service in the present epidemic, was *corallium rubrum*, which was indicated in children as well as in some adults, where the cough would resemble that of whooping-cough, a hoarse barking and croup-like tone. Auscultation would reveal bronchial râles and wheezing.

For the head symptoms belladonna was useful when there were violent throbbing and stitching pains, red face, glittering eyes and dilated pupils.

Cimicifuga in pains in the eye-ball and behind the eyes, pain in the occiput and back of the neck, soreness of the muscles, and sensitiveness and restlessness. *Glonoin* in pains in the head, which were so severe that the head feels as if it would burst; throbbing in the head, with red face. *Hyoseyamus* in stitching pains and signs of meningeal irritation. For the sore throat of the gripe phytolacca appears to act best, though in this year's epidemic he has not observed many throat cases.

Arsenicum acts very well when its indicative symptoms are present. As a prophylactic it has acted well. If the disease has broken out in a house, a daily dose of the 3x may prevent its spreading. It is of service to every one during the prevalence of an epidemic of gripe. Plenty of good and nourishing food is necessary; if solid food cannot be taken, nutritious soups may be administered.—*Allgemeine Homœopathische Zeitung*, Nos. 13, 14, 1900.

Frank H. Pritchard, M.D.

HOMŒOPATHIC REMEDIES IN FLATULENT COLIC.—In the Danish journal, *Homœopatisk Tidsskrift*, No. 2, 1900, the following remedies are advised:

Carbo Vegetabilis.—Great sensation of distention and weight in the abdomen; the stomach feels distended as if by a heavy and pressing weight; the bowels feel filled with wind to bursting. The wind seems to be in the stomach as well as in the bowels. The patient emits much wind without any exertion but without feeling any better. The pain from collection of wind does not seem pronounced.

China.—Distention of the stomach accompanied by bitter eructations as well as gulping up of food which does not relieve. The sense of fullness is improved by moving about (contrary of *bryonia*). *China* is especially indicated in cases due to abuse of tea; as a rule the colicky pains are distressing at night. Patients with nervous exhaustion and weakness are the class in which it seems useful.

Argentum Nitricum.—The gas is limited to the stomach alone, with difficult eructations after eating, and with a sensation as if it were difficult to overcome the resistance of the cardiac orifice of the stomach. When it finally yields, the gas rushes out with great force and in great quantity.

Bryonia.—Great distention and soreness of the abdomen, especially of its uppermost portion; griping and colic, with pains which interfere with breathing; the best movement aggravates the condition. Hiccough and eructations immediately after meals; the eructations take place easily.

Lycopodium.—Slight distention of the abdomen, with a great deal of gas in the intestines, especially in the small intestines. The wind appears to be incarcerated and presses up against the diaphragm; sensation of a rope about the waist, and at the same time a feeling of pressure in the rectum and the bladder. The gas causes a great deal of noise and rumbling in the abdomen, and there is a colicky griping before the flatus slips out. *Lycopodium* is one of our best remedies in wind colic.

Nux Vomica.—The diaphragm is pushed upwards, but only two or three hours after eating; there is a sensation as if a stone were in the stomach and under the ribs. At the same time there is colicky pain and vain pressure and urging to stool. The pain is greater than with *lycopodium*, which it otherwise greatly resembles.

Frank H. Pritchard, M.D.

THE HAHNEMANNIAN MONTHLY.

JULY, 1900.

THE FACIES SYMPATHETICA.

BY O. S. RUNNELS, A.M., M.D., INDIANAPOLIS.

It is not yet seventy-five years since Daguerre succeeded in obtaining permanent pictures by the action of sunlight. Prior to that time portraits and scenery were laboriously and faultily reproduced by the brush and pencil, and these could be duplicated only by the same wearisome method. There was then no known process by which accurate pictures of any object could be taken at snap-shot and be reproduced at will by any tyro; there had been no acquisition and utilization of knowledge that would enable a non-expert to take a picture true to nature and to give it lasting embodiment for the use of all.

How photography has been developed till it serves the ends of science and art in endless detail, and how immeasurably valuable it is to our race at this time, it would be impossible to recount. Suffice it to say, the camera has served to make this the pictorial age, and no portrayal of knowledge is complete without its use, either direct or indirect. Imagery picture-making as a means for the dissemination of knowledge is now recognized as of greatest value—the photograph or the radiograph, in miniature or as magnified upon a screen, conveying to the mind at a glance the thing portrayed in true perspective and proportion. No teacher can attain highest success who is not able to visualize his subject—who is unable to image it for the ready comprehension of all; for every pupil must be able

to see the thing, either literally or figuratively, before he can comprehend it.

This fact has been understood more or less clearly since the dawn of knowledge. The greater the skill in the use of the pictorial, the greater the ability to impart knowledge to men. Whether by legend, allegory, fable, history, experiment or actual picture, matters not, if the mind is thus the better enabled to grasp and appropriate the idea.

While all this is germane to the acquisition of knowledge in general, it is none the less applicable to the requirements of learning in the profession of medicine. No real advancement was made in medicine till mystery gave way to fact; till men began the study of medicine in the concrete and learned that all things have an individuality, and must be studied first as units. This it was that led Hahnemann to the discovery of the law of drug-action, and to his insistence that drugs must be proven singly in order that their characteristic powers may be utilized.

When it was known that drugs have the power to cure the conditions in the human body similar to those that they themselves have the power to create, therapeutics commenced to rank as a science, and drug-prescribing came under the domain of law. How this result has been achieved by the faithful taking of the disease-picture in each instance, and the patient search for its similar among the drug-pictures of the *materia medica*, is alphabetic knowledge to all in the van of progress to-day. It has been the utilization of the pictorial in therapeutics; the cultivation of the faculty to take an accurate picture of the disease condition, and to find its correspondent among the drug-photographs; the study of the individual both as to the disease in question and the drug applicable to its cure. This has made the good physician an analyst; has made of him a close prescriber; has led him to study causes as well as effects, and has enabled him to discern when and when not drugs are applicable.

It is remarkable how perception is quickened in its growth by the effort to take accurate and ever more accurate pictures; how all the smaller details in the make-up of an image become important in the completion of the individuality, and how the recognition of the correspondences and differences appeal to the

artist at a glance. It is these countless variations from a common type, called characteristics, that make all the difference between the genus and the individual. It was the "warts and all" of Oliver Cromwell that made him peculiar to himself, and recognizable at a glance wherever found. And it is this ability to perceive differences, and to recognize peculiarities at a glance, that enables one intuitively, or as by instinct, to arrive at a right conclusion.

It is by such method that the expert is trained in any profession, and particularly in ours; and it is to quicken such acquisition that I claim your present attention.

The facies is the general exterior appearance of anything, or the way it looks from the outside, and with reference to health and disease is indicative of the special and peculiar expressions of nature brought about by physical embarrassment of whatever sort. It is the *ensemble* of objective signs presented by any malady, and is often so characteristic as to require no interpretation. It is an etching so admirably drawn as to denote with great accuracy the exact and peculiar physical condition which, when once seen, can never be forgotten. It is that expression of nature recognizable at a glance that is alone competent, very often, to determine diagnosis, treatment and prognosis; that furnishes the observer with the clue, at least, to the situation, and enables him to pursue his investigations to an intelligent and satisfactory issue. It is that mute presentation so often encountered that enables the physician to write the history of a case without so much as asking a question.

The first to go on record in his description of such an appearance was Hippocrates, five hundred years before Christ. So accurately did he describe the indications of approaching death, and the condition, also, that may result from long-continued diarrhoea, that it is known as the facies hippocratica to this day, viz., "the sharp nose, the hollow eyes of lack-lustre, the collapsed temples, the cold contracted ears with lobes turned outward, the skin of the forehead rough and distended, or drawn like parchment, and the face green, black, livid or lead-colored."

It was Sir Spencer Wells who first instanced the facies ovarina, characteristic of ovarian cysts, and summed it up as follows: "Very high cheek bones, a sharp nose with sharply

defined nostrils, compressed lips, depressed corners of the mouth, deep wrinkles in the vicinity of the mouth, and a furrowed forehead."

Behold the *facies cholericæ*—the picture of malignant cholera: The eyes are sunken, or red and congested, the cornea is flattened, the space between the orbits is livid, the features pinched and rigid, the lips and tongue are purple, and the complexion thick and muddy. The fluids of the body having been ejected as by flood, he has suddenly become emaciated, pinched, shriveled and cold.

Who does not know the *facies agonique* of cardiac disease, the *facies cancerosa*, the *facies gastrica*, the *facies hysterica*, the *facies hydrophobiæ* or the *facies tubercularis*?

We come now to the consideration of the *facies sympathetica*, the parts of which, when taken together, constitute a picture of such distinct and characteristic outline as to stamp it with the familiarity of an old friend. While this is perhaps a new coinage, so far as the name is concerned, inasmuch as I have not seen or heard of its use in our literature or speech, I am yet persuaded that it stands for a thing of very large proportions that is but now for the first time beginning to claim from the profession its merited attention, and that is destined more and more to dominate the thought of every physician who endeavors to cure diseases of a chronic character. For the image in question is presented almost invariably by the long-time invalid who has made repeated, persistent and ineffectual effort to get well. Like the woman with "an issue of blood for twelve years" who came to Christ, and who had suffered many things of many physicians, and who had spent all that she had and was nothing bettered, but rather grew worse, so the sufferer under your consideration may have been treated for almost any and every malady on the list by the most "eminent" physicians of the vicinage, through all the long years, without any lasting and satisfying result.

Notwithstanding all that has gone before, in the patient's experiences, you notice at a glance that ordinarily the patient looks pretty well; there is little or no emaciation, the expression is not haggard or gaunt or worn, and to your question, "Do your associates give you credit for all your bad feeling?" the answer comes, "No; they think I am pretending." It

may be an "issue of blood," an ulcer, a fistula, or a skin disease for which the long and ineffectual professional treatment has been given, and concerning which perhaps the learned opinion has been rendered finally: "It must not be stopped; Nature must have this issue or it will kill you!" I hope, however, such an opinion as the one just instanced will never be considered professional.

Going further, you will find such sufferers subject to "spells" of some sort. They have periodical headache, gastralgia, or "heart disease;" they have symptoms galore, referred to any and every part of the body; and, so far as they are concerned, the diseases are genuine of which they complain. If a female, she is apt to be hysterical and to faint away upon little or no provocation; if a male, he is hypochondriacal or cowardly, and neither of them has any strength or reserve force when extra exertion is called for. They are easily frightened, highly sensitive, and more or less tainted with melancholia. They may be expected to desert or run in the presence of danger, to fail always at the critical moment, and to take council of their fears rather than their hopes in every strait of their affairs. Their candle is forever burning, but is never consumed; they are forever complaining, but are never cured; and usually they are going from doctor to doctor seeking cure, but getting it not.

In the earlier stages of all such experiences the diseases are functional, and not organic; the symptoms are manifold and of wide extent. Every region of the body may be represented on the symptom list, or some particular organ may be called upon to tell the story. Applying up-to-date methods of diagnosis, you may be wholly unable to find any organic affection or to fix and determine any of the maladies of which they complain. But you must regard them none the less attentively on that account. No organic disease was ever such at the beginning. Organic disease is always preceded by functional incapacity; by more or less prolonged expression of inability, manifestations of weakened powers, and faulty performance of life-exercise. It is thus that organs lose their ability to fulfill their mission and become crippled. It is thus that they are held in bondage and are not permitted to regain their function.

If the real doctor, however, has arrived before the inception of organic disease, well and good; the cure will be simple and easy; if his coming has been delayed till organic changes have taken place, he may yet be in time to regain the position by assisting to the adequate regainment of lost life-force. In any event, he will fail of his duty if he does not see to it that all occasion for the inception and continuance of the discord among the life-forces is discontinued. For every chronic invalid is the victim of physical embarrassment; has been forced to pay tribute in sympathetic nerve-force till penury and want are at his door; till his capital has been exhausted; till at last he is a veritable beggar for force, more energy, increased vitality.

Be not so simple as to suppose that the giving of medicine, the correction of the diet-list, the employment of lavage, the use of massage, baths, electricity or climate in such a case will be adequate to the cure. If you do not want an undertaker to finish your work, or some other physician to follow you in the treatment and cure of the case in question; if you desire to discharge your full duty to your patient, and to effect a speedy and permanent cure, you should lose no time in ascertaining and banishing the thorn he is bearing in his flesh that is solely responsible for his facies sympathetica; you should see to it that his abdominal brain is not nagged and fretted to death, and that the subconscious part of his nervous system—that part that presides over all organic life, viz., the sympathetic—is free from all irritation. Whether it be consumption or cancer, Bright's disease or diabetes, lunacy or insanity, inveterate ulcer or incurable skin-disease that is threatened or acquired, first go to the sympathetic nerve-terminals, and see to it that the morbid conditions present in all such cases are abated. Acquaint yourself with the never-to-be-forgotten fact that all chronic disease is dependent upon vital poverty, and this, in turn, to long-continued nerve-waste; that nerve-waste is a matter of the sympathetic nervous system rather than of the cerebro-spinal, and that nine-tenths of all such causation is to be found below the equator of your patient.

After the removal of the *causa occasionalis*—the thing that has been and is responsible for the perturbation in the given case—the cure, if attainable, will follow as a matter of

course. The abatement of the cause leads to the cessation of the effects. The indicated remedy will then prove effective, and the adjuvants intended to aid in the restoration of lost energy will serve their purpose.

This is the most important lesson to be learned by the earnest physician to-day, and no preconceived opinion or blind prejudice should stand in the way of its acquisition.

LOCAL ANÆSTHESIA.

BY F. C. BENSON, JR., M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, October 3, 1899.)

WHILE it is probable that local anæsthesia will never entirely take the place of the general anæsthetics, yet in later years, and especially since the advent of Eucaïn, much more surgery has been done under the local method of anæsthesia than was before thought possible. We all must meet with cases where a general anæsthetic is contra-indicated by the patient's condition, countermanded by the patient's wishes, or where the operative area is so small or circumscribed that the risks attending a general narcosis seem unwarranted; it is in these cases that local anæsthesia finds its greatest field of usefulness.

Unfortunately all the methods now in vogue for obtaining local freedom from pain are attended by certain disagreeable and at times dangerous effects or sequelæ; and it is to a short consideration of these disadvantages, as well as the advantages of the local anæsthetics at our command, that I invite your attention to-night.

In inducing local insensibility to pain we are limited to two methods:

1. By the application of some agent to the surface which will cause such a rapid loss of body heat that the part soon becomes numb, and, if pushed too far, solidly frozen; and

2. By the local application or hypodermic injection of some substance capable of causing a temporary paralysis of the sensory nerve-fibres of the part—also a modification of the second method, in which a neutral fluid is injected into a localized area

with considerable pressure; the anæsthesia here being caused by an artificial ischæmia, direct pressure upon the tissues and lowered temperature (the fluid used in this method being generally below the temperature of the body).

The first method requires less consideration than the second, for we can readily see that its field of usefulness is necessarily limited. We cannot freeze a large area of tissue for fear of sloughing, such as occurs after frost-bite; neither can this method be used in the walls of the mucus tracts, where anæsthesia is so frequently desired.

Again, anæsthesia by this method, as a rule, is limited to the skin surfaces only, not permitting of any dissection. Its chief use would seem to be in cases where simple incision is needed, and especially in tissue which is tense from inflammatory exudate; here the introduction of a fluid into the already over-distended tissue causes considerable pain. Several substances have been used to cause a marked local refrigeration; cracked ice mixed with salt has been placed in gauze bags and brought into contact with the surface. Besides being tedious, this method anæsthetizes too large an area of tissue. Ether has also been used for the same purpose, being sprayed upon the skin by the ordinary hand-atomizer, and, while an improvement upon the cracked ice and salt, was not nearly so useful as a later method, now in general use, the Chlorid of Ethyl spray. This fluid being contained in tubes having a capillary outlet, the spray may be directed upon a small area and thus rapid freezing of the part results. This is probably the best local anæsthetic to use in operating the circumscribed inflammatory lesions, as abscess, furuncle, carbuncle and whitlow. Perhaps to these methods should be added the application of crude carbolic acid; for, although seldom used as a local anæsthetic, it possesses that quality to some degree. I have used it with success in rendering painless the introduction of the hypodermic needle, and for obtaining the small bits of tissue to be used as skin-grafts, often the method of Reverdin—the anæsthesia here, of course, not being due to refrigeration, but to a local charring of tissue. In considering the *second* method we find three substances in use. Cocain hydrochlorate in solution; salt solution (the infiltration method of Schliech), and solutions of the hydrochlorate of Eucain.

Cocaine, or, as it is generally termed, cocain, is an alkaloid obtained from the leaves of the *Erythroxylon Coca*; the hydrochlorate being used for local anæsthesia in solutions varying from 1 to 10 per cent., prepared in distilled water.

Until two or three years ago Cocain was more frequently used than any other local anæsthetic, and, indeed, is still used by many surgeons to the exclusion of all others. But Cocain is open to many objections; it is a toxic drug, exerting its poisonous influence when least expected, and in the weaker as well as the stronger solutions; the toxic effect would seem to be a partial paralysis of the nerve-centres governing the muscles of respiration. More than a dozen deaths from the use of this drug are on record. Personally, I have met with but two cases of Cocain poisoning; in one, the solution was applied directly to a mucous growth in the mouth, and in the other injected into the tissues of a foot in exploring for a foreign body. In both cases a 4 per cent. solution was used, and in both the symptoms were the same—pallor, slow pulse and respiration, rigid muscles and fixed pupils. Heat, artificial respiration, and the use of brandy and strychnia, hypodermatically, was successfully used in both cases. So great is the fear of this drug entering the general circulation that it is advised to ligate the part above the field of operation; this, of course, being possible only when operating upon the extremities. Another disadvantage in the use of Cocain, arises from the fact that the solution cannot be rendered sterile by boiling. Cocain is frequently used in plastic work about the face and in operations upon the male urethra, but when we take into consideration the fact that both the mucous membrane of the urethra and the tissues of the face are *especially* liable to absorb and carry into the general circulation any poisonous drug, I feel that we should avoid injecting into these localities the solution of an alkaloid known to possess toxic properties.

I have had very little experience with the infiltration method of Schleich. He used first a salt solution, and to induce anæsthesia distended the part by wide infiltration. Later, small quantities of Cocain and morphin and carbolic acid were added to the solution. Quite extensive operations have been done by this method; its disadvantages are that it cannot well be used in inflamed tissue, and that there is danger of the infiltrated tissue sloughing, due to tension necroses.

Finally a brief consideration of the hydrochlorate of Eucain, one of the later, and I believe the best local anæsthetic now at our command. Eucain was introduced some two or three years ago by Schering as a substitute for Cocain, and, unlike it, is a synthetic product, being a methyl-ester of a methyl-benzoyl-triacetone-alkamine-carbolic acid. Later, a new compound of the same class was introduced under the name of Eucain "B," the claim being made that this preparation was somewhat safer, and also did away with a certain burning in the tissue, sometimes caused by the original preparation; or, as it is now called, Eucain "A." In general surgical work there seems to be little difference in the anæsthetic effect of the two compounds, and from long-continued use I have come to look upon both preparations as being practically harmless. It is used in the strength of from 2 to 10 per cent. ($4\frac{1}{2}$ to 18 grs. to the ounce), and presents many advantages when compared with Cocain. In the first place it is safer; it can be boiled without changing any of its properties, and by its use anæsthesia is more quickly induced, and lasts longer.

During the past two years I have used this anæsthetic in a large number of cases both in the out-patient department of The Hahnemann hospital as well as in my own practice, and during all this time I do not recall a single case showing any toxic effects from its use. To illustrate the number and character of the operations being done under this anæsthetic, I refer to the operating-list of the hospital out-patient department; it shows during the past six months a total of 120 operations done with Eucain, as follows (this does not include a number of operations performed in the Genito-urinary and Orthopædic departments):

Abscess, 14; Foreign bodies removed, 2; Cysts enucleated, 21; Epithelioma, 5; Enchondroma, 2; Myoma, 1; Keloid, 1; Lipoma, 5; Neuroma, 1; Adenoma, 1; Papilloma, 1; Fibroma, 3; Ulcers, curettement, 5; Ingrowing nails, 23; Wound suture, 7; Circumcision, 1; Irritable scar, 1; Whitlow, 1; Plastic operation, 4; Cellulitis, 2; Necrotomy, 4; Amputation finger, 3; Amputation toe, 2; Sinus, 3; Tendon suture, 1; Exploratory incision, 3; Fistula in ano, 2; Fissure of anus, 1; Total, 120.

I have twice used as much as four drams of a four per cent.

solution at one time, namely: in a breast amputation and a finger amputation with resection of the metacarpus, and in neither case were any bad results manifest. In my hands Eucain has proven a desirable anæsthetic in the surgery of the rectum, having operated fistula, fissure and external hæmorrhoids under its influence with considerable success. It is claimed that the injection of Eucain causes sloughing; my experience leads me to believe that the cases of sloughing are caused not by any property of the drug, but from the fact that too much fluid is forced into a certain area of tissue, causing a similar tension necrosis to that following the infiltration method. Two slight disadvantages connected with Eucain are that it dilates the capillaries and that tissue infiltrated by it is hardened to some extent—the first causing free oozing, especially about the face, and the second presenting some slight hindrance to the introduction of the suturing needle. After several years' work with local anæsthetics I have reached these conclusions: in inflammatory conditions, when incision only is desired, the freezing method by the Chlorid of Ethyl spray is to be preferred; in non-inflammatory tissue, anæsthesia by the injection method, using preferably hydrochlorate of Eucain in a sterile 4 per cent. solution. That great care is necessary in the sterilization of both skin and hypodermic syringe, and that the injection should be given slowly, follow the line of proposed incision, and in infective cases the needle should never penetrate the diseased area before entering normal tissue.

The ideal local anæsthetic is yet to be found; a number of experiments have recently been made looking to the discovery of a method that would do away with many of the dangers and disadvantages of those now in use, but unfortunately the results of these investigations are not far enough advanced to be published at this time. Even with the imperfect methods at our command much work is being done that not long ago was thought to be almost impossible without general anæsthesia, and we look forward to a time when a perfected method of obtaining local insensibility to pain will enable us in many cases to avoid the dangers attending the administration of chloroform and ether.

HYOSCYAMUS IS INDICATED IN TYPHOID FEVER when there is violent delirium, sleeplessness from nervous excitement, subsultus tendinum, grasping at flocks, red and hot face; red, staring and sparkling eyes.

VIBRATORY MASSAGE IN CHRONIC EYE DISEASES.

BY W. C. COMSTOCK, M.D., BALTIMORE, MD.

DURING the past few years the methods of treating and curing the diseases of mankind have undergone great changes. What was thought formerly to be impossible, or at least irrational, now plays an important rôle in the battle with disease; and yet even now we are forced to admit that our system is still imperfect, that medical science is still in a state of evolution. New theories are springing up almost every day, some of them enduring the test of time and experience, while others soon run their short course and are forgotten. This state of things may appear to the outside world as a chaotic picture, calculated to breed skepticism and doubt as to the genuineness of the so-called medical science, but to those deep in the theoretical and practical phases of medicine this is a most interesting age. Back of this experimental haze is a strong current of conservatism, which is a virtual balance-wheel, allowing the healing art to keep even pace with other sciences, and yet never discarding the old until the new is well established. The tendency of the times is fewer drugs and smaller doses, aided by proper diet, exercise, climate, environment, skillful surgery, various electrical appliances, baths and massage, the last of which claims the attention of this paper.

For a number of years the beneficial effects of massage of the various parts of the body have been well recognized. Muscles atrophied from disuse or tissue weakened by systemic affections become strong when properly massaged. It is one of the practical sides of medicine often neglected, and, many times, carefully selected homœopathic prescriptions would be less censured if allowed to act in stimulated tissue through an enlivened vascular system the direct result of massage. Its usual method of application is familiar to all. Kneading, rubbing, and other manipulations by the hand or instruments on the surface of the body have a decided effect in both local and general nutrition, as well as the functions of some of the internal organs. This mode of applying massage is necessarily limited to

exposed tissues of the body, while other parts, as the eyes, are, from their anatomical surroundings, unable to receive such treatment to much advantage. Heretofore massage of the eye has been limited to rubbing the closed lids over the ball by means of the finger-tips, producing an effect necessarily confined to the external surface. Even this form of treatment has been effectual in certain corneal diseases where scar tissue has resulted, and leucomas which were opaque have been reduced in size and made more transparent. Intraocular troubles of course are not at all affected by this means of manipulation.

By the title of this paper, "*Vibratory Massage in Chronic Eye Diseases*," it will be understood at once that the method of applying this treatment is not by manipulation of the surface of the eye-ball through closed lids with finger-tips, but by a vibratory movement of the eye as a whole. This method is entirely new, and has been in use but a short time by a few physicians of this city. It has passed the experimental stage, and has demonstrated its great usefulness in deep-seated eye diseases, making curable a great many cases which otherwise would lead to total blindness.

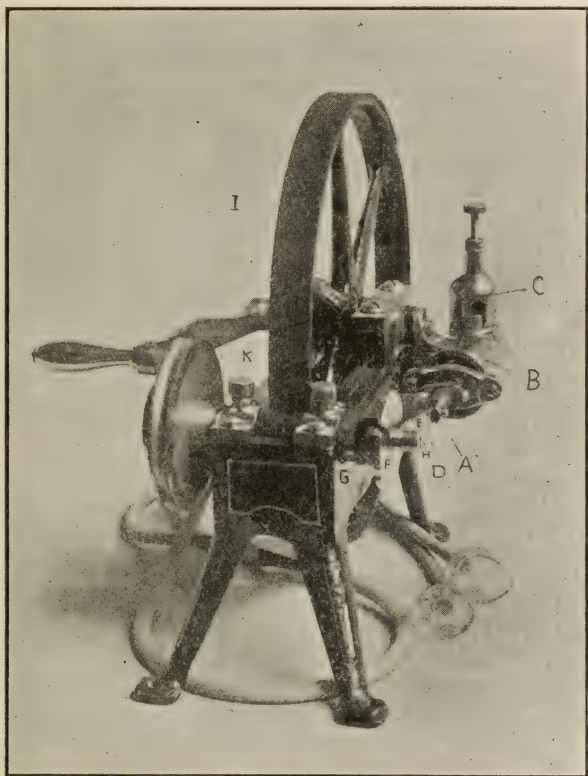
Massage, as far as I know, has never been thought of before as a means of reaching such conditions of the eye, but, as just stated, was confined to external troubles only. A treatment which benefits by stimulating the blood supply and absorption of effete materials finds no tissue in the human body better adapted to its application than the eye. The whole scheme of vision is to a great degree dependent upon a perfect transparent media. The aqueous and vitreous humor and the crystalline lens should offer no resistance to rays of light as they penetrate the ball, if the objects in the field of vision are to be normally pictured on the retina. Unfortunately a hazy vitreous is the result of some of the intraocular inflammations, and although the active inflammatory stage of these diseases may pass away, the vitreous scar is very apt to remain, with a consequent dimness of vision. Careful prescribing has benefited these cases, but oftener they are so tedious that the patient becomes discouraged, and, despairing of relief, is resigned to a lifetime of cloudy vision. It is too much to expect of any form of treatment to restore lost tissue in these cases, but if there is any way of aborting the active destructive pro-

cesses of the disease, or if, seen in the chronic state, there is some means by which we are able to arouse the activity of the organ to such a degree that the cloudiness of the media is absorbed, then surely there has been an advancement in the scientific treatment of eye diseases and a blessing to groping humanity. The method of vibrating the eye as a whole, as a massage for intraocular diseases, was conceived by Dr. Henry F. Garey of this city, who has also designed an instrument, which he calls *The Intermitting Vacuum Pulsator*, for applying this form of treatment. This instrument is simple in its construction, and merely applies the principle of alternate suction and release over the parts treated. It is composed of a pneumatic pump and two valves, worked either by hand or electricity. A rubber tube is attached to a vacuum cylinder, and at a proper distance is divided, and on the end of each of these divided tubes is a hollow cup, so shaped as to fit snugly within the orbit, thus forming a fairly good airtight chamber over the eyes. As the vacuum is produced in the cylinder the effect extends through the tube to the eye-cup, and as a vacuum must cause suction, the eye starts forward in its orbit. At the end of the piston-stroke a valve opens, allowing the air to fill the vacuum, when the eye resumes its original position by the elasticity of its own tissues. The forward and backward movements thus produced constitute a complete vibration. Any pressure on the eye-balls is avoided by the escape of air from another valve on the return stroke.

Although this paper is on the eye, it might be briefly mentioned that this instrument is also used in certain ear affections. By the action of an adjustable break-valve, an effect of a sudden jerk and release is produced on the *membrani tympani* which, in my opinion, does more good in breaking up adhesions than any other means at our command. A short stroke with great speed will also produce a sound-wave, thus combining in the one instrument vibratory and sound massage.

The beneficial effects of this treatment when applied to the eyes are immediate. The traction on the eye-ball is so uniform and gentle that intraocular hæmorrhage is not to be thought of. It is pleasant and painless to the patient, as is proven by children, who submit to its vibrations without complaint. The effect produced is a feeling of clearness before the eyes.

Everything seems bright, and any tendency to neuralgic or heavy pains in the eyes is gone. This stimulating effect to vision and relief from a tired, strained sensation are very apparent in doing refractive work. After a patient has undergone a rigid examination his eyes smart and burn, his temples ache, and his vision is blurred, making the objective tests most unsatisfactory. At such times two minutes of vibratory mas-



sage will stimulate the parts, relieving the patient of all feeling of fatigue, when the refractive examination can be completed with much better results. In other cases, when great care has been used in prescribing the proper lenses, and the repeated use of mydriatics convince the physician that the proper glasses are being worn, and yet the patient complains of burning of the lids and inability to use the eyes for any length of time without pain, it has been proven, in such conditions, that

the stimulating effect of massage is the panacea, as all such symptoms disappear after a few treatments. An external disease which is annoying to the patient and usually tedious to treat is episcleritis. Salicylic acid and iodid of potash are the routine remedies used among the allopaths, while the different potencies of mercurius, thuja, sulphur, sepia, etc., are employed by homœopathic physicians, yet neither school gives a favorable prognosis as to the duration of this disease.

Dull heavy pain about the eye with more or less ciliary neuralgia always accompany this affection, and are slow to yield to any internal medication or collyrium. Experience has proven that vibratory massage in a single treatment will relieve the pain entirely, and by its continued use the course of the disease is materially shortened, and the dull area of discoloration of the sclerotic, which usually marks the seat of the disease, is rapidly absorbed.

In glaucoma, where there is considerable increased tension and contraction of the nasal visual field, with more or less pain at intervals, the prognosis is gloomy. Eserin in weak solutions instilled into the eye, internal medication or an iridectomy, would be the only means at our command to relieve this unfortunate condition, which in the majority of cases results in total blindness. Vibratory massage is particularly applicable in these cases. The pain is relieved at once, and after a few treatments the contracted field begins to widen and the tension decreases. The true nature of glaucoma is not very well understood. It is known that it may follow severe neuralgia of the fifth nerve, injury to the ball, worry, overworked ametropic eyes, etc.; and it is also known that the pathological changes in the advanced stages of the disease are mostly confined to the iritic angle which is the point of filtration of eye fluids. So we are led to believe that glaucoma is a direct consequence of a disturbed secretion or excretion. Knowing this much pathology, it is most rational to assume that if massage has any merits glaucoma is amenable to its use. The loose trabecular tissue of the filtration angle is stimulated to normal activity, with the result that excretion goes on and the symptoms fade away. In cases of choroiditis, where excessive pathological changes have taken place with loss of tissue, it is unreasonable to suppose that any form of treatment will replace

it, but by means of vibratory massage the remaining structures are made healthy, and the media cleared to such a degree that vision in a single treatment has been increased from $\frac{20}{150}$ to $\frac{20}{150}$, with continued improvement.

I have used the intermitting vacuum pulsator in my office but a few months, so have not cases covering a very great period of time to illustrate this method of cure, but Dr. Garey, with whom I have been more or less associated in experiments, has used the instrument a much longer time. He has on record a case of incipient diabetic cataract where not only the progress of the disease has been stopped, but vision has been increased from $\frac{20}{150}$ to $\frac{20}{60}$.

These are only a few of the many eye affections which yield most satisfactorily to vibratory massage, yet these are sufficient to assure the future of this method of treatment. Massage is not intended to displace all the old practices, but to act in conjunction with or without them, curing in a much shorter time those cases that are curable, and of making curable many diseases which no treatment seems to benefit.

THE FACULTY ADDRESS TO THE ALUMNI ASSOCIATION OF HAHNEMANN COLLEGE, MAY 17, 1900.

BY PEMBERTON DUDLEY, M. D., LL. D., DEAN, PHILADELPHIA.

At the Fifty-second Annual Session of the College, just closed, there were in attendance an aggregate of two hundred and sixty-four students. Fifty-eight—or about twenty-two per cent. of the class—passed the final examination and will receive the Degrees of the College this evening. All of these graduates have been earnestly urged to unite at once with the Alumni Association.

Eight of the graduating class—nearly fourteen per cent.—are holders of academic degrees, and several more have enjoyed the advantage of partial courses in literary colleges. Of the balance, a considerable majority are graduates of high schools or of normal schools, or hold certificates of reputable academies.

The educational status of the last Freshman Class shows a continuance in the process of annual improvement, and espe-

cially in the purely literary departments of preliminary training. But in relation to preparatory training in the general sciences, the evidences of progress are less pronounced. We are doubtless justified in the expression of some pride in the efficiency and standing of our College, and yet there is no member of its teaching body who does not feel the need of incessant and rapid improvement. It is useless to close our eyes to the fact that the preparatory education of the average student of medicine is not nearly what it should be. The "Common-School Education" of the present day, so far from being adapted to the requirements of the medical course, is defective in two important particulars: It fails to enable the student to express himself with facility and freedom in correct English, and it leaves him destitute of a knowledge of the relation between word-construction and definition. This latter defect is the direct result of the modern exclusion of etymology from the public-school curriculum, and its effect upon the medical student at the beginning of his college course is to render most of its technical terms incomprehensible to him, and thus to make his first lessons vastly more difficult. It must be said, also, that even an elementary acquaintance with the Latin and Greek languages does not altogether compensate for this defect in an English education.

The other point in which the preparatory education of the average student of medicine is deficient is in the matter of general natural science. In some reputable literary colleges the course leading to the baccalaureate in science includes little more of the subject than physics, chemistry and botany, with something in comparative anatomy and physiology; while in the average high school and academy the facilities for studies in general science are of the most meagre description. Thus it is that Hahnemann College is compelled to devote a large part of the student's first year to preparatory instruction in general science—a department of knowledge which should properly be cultivated prior to matriculation in the medical school. Numerous other colleges of the United States have recognized the same necessity.

How these deficiencies in our methods are to be finally remedied it is not easy to decide. The medical profession, even if acting in concert, might find it difficult to influence the

methods in vogue in our common schools, and many of our prominent literary colleges adapt their courses of instruction almost exclusively to the (supposed) needs of the purely literary vocations, to the detriment of our more "materialistic" profession of medicine.

The proposition to require an academic degree as a preliminary to the medical college course has aroused among a certain class a very earnest advocacy. It is significant, however, that this "class" does not include a very large percentage of practical and experienced medical teachers. The well-nigh insurmountable series of objections likely to be raised against it are: First, The method makes it impossible for the student to graduate before the age of twenty-six years, even if his entire time and attention be devoted to his work of preparation, and his actual professional life is not fairly begun until half the average lifetime of the physician is gone. Second, The method requires that the candidate's decision to study medicine shall be made at the age of fourteen (when he is leaving the grammar school), or at the age of eighteen (when he is leaving the high school), or else he is in danger of directing his energies toward some other vocation, and thus deferring his graduation to a still later time of life. Third, The pecuniary cost of such a course as the one under consideration is so great as to exclude from the profession the majority of those who enter it under the present system, while those who could buy their way into it are not always, or even usually, the men best adapted to assume its responsibilities.

If the individual opinion of the writer of this report is of any value, he would like to say that if the course in our elementary public schools were made what it should be, it would be an easy matter to arrange an advanced course of study, to follow that of the grammar school, which would thoroughly qualify the candidate to enter the medical college in four years—namely, at the age of eighteen—and permit his graduation at the age of twenty-two. Nor would he then be obliged, as the average medical student now is, to devote his first medical college year to the work of completing his preparatory education.

But such a course of advanced preliminary education as that to which allusion has thus been made is not obtainable in any

literary school of which the writer has knowledge; nor does it seem probable that the near future will see such courses established, unless by the medical colleges themselves. For this reason, some of the members of our Faculty have more than once expressed themselves as in favor of the maintenance of special preparatory departments by the medical colleges, precisely as departments of similar designation are maintained by many literary colleges. And if such schools are to be under the instruction of men trained in medicine and familiar with its necessities, then the sooner they are established the better.

ACUTE DEMENTIA.

BY W. B. CARPENTER, M.D., COLUMBUS, OHIO.

(Read before the Ohio State Homœopathic Medical Society, at Sandusky, May 8 and 9, 1900.)

My attention has been especially called to this trouble lately by its development in one of my patients, a woman nearly 65 years of age. During and following the long attentions incident to an exacting chronic illness in her family, errors in memory were first noticed, with at last its comparative loss. No melancholy or suicidal tendency has been noticeable at any time; she will sit for a long while in any position assumed or given, without reference to surroundings; she is apathetic, vacillating or self-absorbed; appetite is large, and the nutrition of the physical organism fairly good. There seems to be no doubt as to the diagnosis, and proper hygiene and treatment are aiding in restoring what was lost. Here certainly was an acute condition, with no reference to ailments of her own or to any state that pre-existed to lead to it. This brought to my mind the fact that this trouble is too little understood or noticed at all in some cases, and the further fact that it is often confounded with *melancholy with stupor*. Dementia is mental impairment, acquired, in distinction from amentia or imbecility where mental power never existed, at least to any extent. In dementia there is enfeeblement of the intellectual, emotional and voluntary powers; and it may, and often does, come on as a primary disorder. Strange as it may seem, this disease is

scarcely ever seen as a primary or acute trouble after 30 years of age, and before that age we can and do see it frequently, even down to quite young children, where it many times is not properly recognized. It occurs in both sexes, though mostly in females. By these facts it would seem that dementia depends mostly upon exhausting influences operating at a period of rapid physical growth, where nutrition must both produce new tissue and repair waste in that that is already at work in the body. So the pathological condition here is an "empty storehouse of nerve energy"—exhausted grey matter. Anything, then, will produce dementia that empties excessively these stores or diminishes the restoring of what has been expended. We can thus easily recognize, as causes of this malady, overtaxing the brain or nervous system, shock, fright, grief, injury, terror, anxiety, sexual disorder or excesses, disease, or a tedious routine where there is no variety or spice in life, and where new ideas are not allowed to come. In the case of children, the "bright children," who attract attention by their learning and memory, and are bright beyond their years, their natural gifts are forced till disaster follows. The child is born into a hurried life—everything is noise, rush, bustle and confusion. They are pushed through and away from the food and care of infancy, are early sent to school where the forcing still goes on, or are soon sent to the mills to live and work in monotonous surroundings, requiring monotonously repeated bodily movements. Just at the time when the developing and yet unstable and irritable nerve-centres are greedy for the care, rest and nourishment fit for growth and evolution, our youth must meet the excitements, stimulants or depressants incident to the conditions of modern life; and is it any wonder, then, that we have such an army of neurotics,—many times dements? Remember, it takes relatively small lesions in nerve-centres to produce grave results. As illustrating one cause mentioned for dementia, I want to cite a case just related to me in my home city: A bright, normally developed five-year-old child was punished by having her head thrust under cold water. The shock and fright immediately dwarfed her mental power, so that she is still as childish as at any time, while the body has kept pace in growth with her nineteen years of life. A certain fatuity is seen among the sequelæ of certain diseases,

notably typhoid fever (especially where delirium is present), where a faulty memory and childish manner will be the distinguishing features. Malaria, masturbation, cigarette-smoking, rope-jumping, are others of the anæmia-producing and nerve-exhausting diseases and practices that induce forgetfulness, listlessness, and other conditions that will grow and grow until fatuity or dementia is reached.

In children the symptoms are usually of one general form, but vary in degree. (a) In mild cases they do not seem so bright, they do not work or talk so easily or accurately, are vacillating, there is no self-confidence, no energy, they are confused, apathetic, indolent, emotional or silent, self-absorbed—answering petulantly only in monosyllables, if at all. (b) The more aggravated cases are stupid, no conscious attention, movements automatic, speech silly, erratic or incoherent, memory unreliable, expression perplexed and vacant, are negligent of themselves, their needs and their surroundings. Feeble heart-action with hyperæmia and swelling of the extremities are marked external symptoms, as they are of every case of dementia. In older persons, the symptoms are divided into two forms according as there are delusions or not, the delusional form seemingly being less rapid in its development.

The anergic (wanting force) form shows a rather rapid onset, and the patient is apathetic yet contented, with no marked interest in his surroundings; instead of the assertion there seems to be the negation of power; no energy—they have a routine of life and do as they are told; will sit for hours maybe in the same position in which they are once placed, or possibly they are resistive and will not move when asked, and will return mechanically to their place after they have been forcibly removed. Herein they simulate catalepsy; and, though seemingly conscious, after return to health they cannot remember any such thought or want of thought or action as has just been mentioned. The features are relaxed and passive, eyes vacant and not fixed, pupils dilated, motor system weak; reflexes are dull, there is emaciation, patients are dirty, completely forgetful, apathetic, cataleptic, showing cyanosis and the *tache cérébrales*. In the delusional form, we can almost think we have an example of auto-hypnosis. The patient does not respond to the world, but will attend to his own nature. Some

will show stubborn muscular resistance when they are touched, and will move only when they are pulled along. They do not pay attention to what is said to them, but in case of recovery they can tell of these things, and also of the delusion that was present at the beginning of their trouble. They show comparatively little permanent mental impairment, and a fair memory. The features in these cases are contracted; eyes fixed up or down, or closed for long periods of time; pupils are contracted; there is less vascular derangement; food is usually refused; the patient can stand pain more than usual, and he will pay no attention to such annoyance as flies crawling over the body anywhere; the pulse shows great tension, reminding one of an arterio-sclerosis, and this in fact does exist in many instances.

Referring again to the pathology of the disease, we can say that there is an acute, interstitial inflammatory state of the central nerve-cells (chiefly motor), with swelling and displacement of their nuclei. This gives rise to cerebral œdema. Degenerative changes follow later, and the amount of mental impairment and stupor are measured by the amount of inflammation or atrophy or destruction that the nerve-cells have undergone. The more acute the attack, speaking generally, the better will be the prognosis, which is also the case when there is an absence of delusions. In some of these cases the cloud has been raised, and serious bodily symptoms, more particularly of the lung, will be left. By close study it will easily be seen that there is a great difference between the malady under consideration and melancholia *cum stupore* with which it is most frequently confounded. In a few words, the following classic distinctions between the two will be found useful:

Melancholia cum stupore.

More rapid onset.
Nutrition fails.
Complexion yellow.
Sleep very poor.
Opposition to all movements.
Food refused.

Suicidal tendency.
Some memory after recovery.

Dementia.

Onset more slow.
Nutrition often good.
Complexion normal.
Sleep usually good.
Passive, or less resistive.
Voracious, except in some delusional forms.

Not so.
Memory absent, except in a few delusional forms.

These do not pass one to the other, and "stupor without consciousness, with no mental depression, cannot end in stupor with consciousness with mental depression."

When it comes to treatment, the greatest latitude and good judgment are needed. Constant personal attention is what is needed, consequently it is better many times to not consider asylum treatment, thus avoiding the shock and fright of life in such surroundings. Good hygiene, pure air, proper diet and exercise, constitute a very large part of the treatment. Rest, sleep, nourishing food at frequent intervals, and forced exercise, with a cessation of whatever has been a contributing cause, do much to repair and restore. Baths will be very beneficial, —the shower baths, prolonged baths, and those advocated under the Schott system. Also, galvanism and massage will aid the circulation. An important aid is warmth, even to a degree that many would call excessive. Speaking of rest, it is many times wise to keep the patient in bed the greater portion of the time during the early part of the treatment.

Aconite, gelsemium, opium, phosphorus, phosphoric acid, kali phos., china, arsenicum, aurum, nux vom., ignatia and anacardium are among the remedies that promise the most benefit, but the selection can only be made when the symptoms at the time of prescribing are fully discovered. This incomplete paper follows several cases under observation lately: the one referred to at the beginning occurring at the unusual age of 65; one at 14, in a girl naturally bright, pushed through a hot-house development till many signs of mental impairment appeared; another one in a little four-year-old, bright and interesting as the average child, who was shut in a dark closet for punishment, and was literally "scared out of his wits."

I know that the experience of every practitioner can supplement largely this report, and discussion and study and proper differentiation of dementia in its primary or acute form will put us a step farther in the treatment of many of these peculiarly distressing cases.

THE PROPHYLAXIS OF BREECH PRESENTATIONS (Meurer).—The writer recommends the examination of pregnant women at the eighth month, and every two weeks thereafter. If the breech presents, turn it by external version into a vertex presentation, using ether if necessary.—*Centralblatt für Gynäkologie*, No. 2, 1900.

REMARKS ON PHTHISIS—ITS TREATMENT—WITH THE REPORT OF A
CASE.

BY EDWARD S. SHARPLESS, M.D., PHILADELPHIA.

(Read before the Germantown Medical Society, April, 1900.)

I MAKE no claim in this hurriedly prepared paper for anything new, but submit it with the hope that the subject brought before your attention may result in profitable discussion, and a dissemination of knowledge in the treatment of this very prevalent and fatal disease.

S. A. Knopf, M.D., in his recent work, has made a study of the sanatoria of the world devoted to the treatment of phthisis, from which I submit the following, giving the number of sanatoria and number of beds:

In Austria, 1; beds, 300; Hungary, 2; beds, 300; free, 1; Belgium, 2; free, 2; Denmark, 3; England, Ireland and Scotland, 25; beds, about 1500, partly free; Germany, 43; beds, about 2400, largely free; Holland, 2; Norway, 5; beds, 390, partly free; Russia, 12, for the poor; Switzerland, 8; beds, 520, partly free.

United States: Alabama, 2; 1 full price, 1 for prisoners; Colorado, 3; not free; Illinois, 2; 380 beds, poor of Cook County; Maryland, 1; Massachusetts, 4; 340 beds, largely for poor; New Mexico, 4; 1 with 31 beds, partly free; New York, Adirondacks cottage system, 100 beds; \$5 per week; and nine others, 800 beds, poor and full pay; North Carolina, 2; full pay; Pennsylvania, 4; pay and free; with the projected Chicago Hospital for Consumptives, endowed by Mr. Otto Young, and the new United States Government Sanatorium at Fort Stanton, New Mexico. Canada, 2; Australia, 1; and Japan, 1.

Here is a great opportunity for a rich philanthropist; not a sanatorium of size in the State of New Jersey devoted entirely to the treatment of consumption. A State whose miles of pine trees, with the resinous odors so grateful and beneficial to this disease, with the soil in the sandy and gravelly regions especially suitable, and with a mild winter climate, must be a desir-

able place for such cases; in fact, in Hammonton and in Vineland there are still alive and quite well to-day many of the original settlers of those towns, who came there from New England towns and cities, many of them with phthisis, and they have found great relief and years added to their lives by the pine-laden breezes of South Jersey.

Admitting that the best results can be obtained in a proper sanatorium for the treatment of phthisis pulmonalis where the surroundings and facilities for carrying out the modern methods of out-door air, excessive nutrition, and rest treatment are well performed by Dr. Dettweiler, of Falkenstein Sanatorium in Germany, and a number of others in Europe; or of Dr. E. L. Trudeau of the Adirondack Cottage Sanatorium, and many others of America. Still we find among our patients a very large number, probably as large as 90 per cent., who, from lack of means or other causes, cannot avail themselves of the advantages of treatment in a sanatorium. And it is for these, who must have home treatment, that we make a plea for a treatment for them which will as nearly approximate to the treatment of these institutions as their circumstances and surroundings will permit of. The usual surroundings of a consumptive are well known to us; in the mechanic and laboring classes we will usually find them in a close, overheated room, with no ventilation either day or night, breathing the same vitiated air with all the other members of the family, probably as many as six to ten in the same quarters, with no especial care as to what becomes of the sputa, the cuspidor being missed at times, so it dries on the floor, and after drying is inhaled in the dust by some other member of the family.

Can we wonder at the prevalence of the belief that consumption is hereditary, which seems to be a question yet open to discussion? Whether the patient inherits a certain predisposition or favorable soil, which, when exposed, receives and propagates the bacillus with extraordinary facility, or that the bacilli is itself inherited by the children of tuberculous parents, either through the mother by infection of the ovum or placenta, or from the father by seminal infection, I leave this for your discussion. Be this as it may, the presence of the tubercle bacilli, as shown by the microscope in a specimen of suspected sputa from a patient with cough, fever, more or less, wasting of strength and

flesh, and the chest symptoms is of marked diagnostic importance, and that may be its greatest importance, as there are numberless cases on record where the patient has gained from 15 to 30 pounds, lost the sputa for the most part and the cough, improved in every way; in fact, feel quite well at most times, and yet the presence of the bacilli is shown on microscopic examination. The suggestion to the patient and family found in these ill-ventilated quarters, that the chance for improvement would be enhanced if there has not already occurred a breaking down of lung tissue and the formation of considerable cavities, by plenty of *fresh air*—that if the patient is not able to be out of bed, the best and largest room in the house, with the sunny exposure for the largest part of the day, with any heavy curtains or hangings removed, the bed moved by the sunny window, the patient covered warmly and allowed to lie there all fine days with a window up, with screens to prevent draft, and the temperature of room not above 65°; or if able to be up, to dress very warmly for very cold weather, and no degree of cold need prevent, and sit out as many hours a day as possible on a sunny flat or roof, or some sunny corner of a yard on a lumber platform made for his easy chair, with such screens or wind-breaks as may be necessary to keep out of a direct draft; exercise or walking could be guided by the temperature, as it will rise in a phthisical patient from too much exercise, and can be lowered by rest and repose in the out-door air.

Dr. Millet, of Brocton, Mass., reports five cases of phthisis in the early stages, who were compelled to earn their living in factories in the day time, being greatly improved in health and weight by sleeping out of doors every night from June 1st for five months following on an improvised platform on a roof, or on a porch, with a cot even sometimes wet with dew or a light rain, they benefited greatly by it. This continuous out-door life, at rest, especially in the cold air, is the method of Dr. Trudeau, and he contends that the fever of the consumptive must disappear under this method.

Food.—Those cases who can take the most food and digest it will do the best. Overfeeding or stuffing should be practised, and as much food taken as the stomach will stand. Raw eggs are especially recommended, beginning with one three times a day, and increasing until twenty or twenty-four are taken daily;

broken in an egg cup, with a little salt, they are easily taken; the yelk may not be broken. Milk, cream, butter, meat and eggs and oysters should constitute the main part of the diet.

Knopf says a very much impaired nutrition, with lack of assimilative powers, should not be treated to forced alimentation, but by rest at first in bed, and later on veranda, regular massage, frequent administrations of small quantities of food, consisting of very easily digested substances, such as scraped or finely chopped beef raw, toast, milk, pure, or with egg in the form of weak egg-nog, bouillons, soups, etc.

The yolks of fresh eggs especially recommended, taken raw several times a day, seem to act by their nuclein as valuable material in the reproduction of new tissue cells, and will be retained often when the stomach tolerates nothing else. One of the most important things seems to be, in the frequency of feeding, not to have the patient wait for the three regular meals a day, but to have the eggs, the milk or koumis half way between meals and the regular meals, making in the whole twenty-four hours at least six feedings.

Medicines.—Thymol, grs. 1 to 3, three times a day, seems to exert an effect on the fever, sometimes causes eructations. Creosote and creosotol or creosote carbonate is more readily borne than creosote, 50 to 60 minims three or four times a day for adults; this is the maximum dose—better to begin with 10 to 15 drops at dose, and increase. Iodoform is recommended for inhalation, 1 to 10 parts ether, or in pills with codeine internally; beechwood creosote inhalations, equal parts of chloroform and alcohol; cod-liver oil, guaiacol or its carbonate; tribasic phosphite of calcium and the phosphate of sodium; codeine for the cough; strychnine, iodine and its compounds, and a host of others. The indicated homœopathic remedy, when found, will undoubtedly accomplish wonders.

Breathing exercises as taught by methods mentioned in almost any book on the subject are of undoubted benefit.

Serum Pathy.—The results obtained from Koch's first tuberculin, made known to the medical world at the International Medical Congress in 1890, when employed for curative purposes, have been almost always at least deeply disappointing if not disastrous. Its diagnostic value cannot be disputed, and in the lower animals it has given, as such, definite results. Manu-

facturers of serums now prepare the strong serum for veterinary use, and a much weaker anti-tuberculin serum for human use. In some sanatoria Drs. Trudeau, Davos, Turban, and in some special hospitals, small doses of anti-tuberculin are continuously used as a curative means, and good results reported, especially in early cases. Dr. Joseph McFarland, of this city, reports several cases in *University Magazine*, Nov. 1897, and Dr. Guy Hinsdale reports two cases favorably in *Journal Climatology*.

The fact that the streptococcic bacilli so often accompanies the tubercle bacilli in the sputa has given rise to some experiments with the anti-streptococcic serum introduced by Marmoreck in cases where the fever seemed to be of a septic nature.

Dr. Knopf's experiments: "The action of the serum was not always uniform; with patients whose temperature rose above $102\frac{1}{2}^{\circ}$ for several days he did not receive any result; but when the temperature was $101\frac{1}{2}^{\circ}$, with streptococci in sputum, first injection of 10 c.c. brought it down from 1 to $1\frac{1}{2}$ degrees; on second injection, 10 c.c. to nearly normal; a third, fourth, fifth and sixth of 5 c.c. every twenty-four hours, then at longer periods, helped to maintain normal, and a general better feeling was experienced by patient."

Dr. Edward Bermingham reports four cases mixed infection tubercle and streptococci. Case 1—dose 10 c.c. reduced temperature $103\frac{1}{2}$ to $101\frac{1}{2}^{\circ}$ three times in three weeks. Case 2—10 c.c. 103 to 101° for four months after one dose. Case 3— 103 to 105° , 10 c.c. and 15 c.c. no effect; 20 c.c. reduced to 102° ; remained down six months. Case 4— 103° 10 c.c. to $99\frac{1}{2}^{\circ}$, remained six months; 10 c.c. then reduced to 100° highest now seven months.

Dr. Weaver, of Chicago, one case 105° , 10 c.c. every other day maintained a nearly normal temperature.

In the case I now report the serums are made by Mulford, and are used in combination.

G. W. S., saloonkeeper; æt. 55 years; troubled for years with chronic rheumatism, attacks of influenza every winter, severe cough, worse at these attacks, but present most of the time; usual weight about 160 pounds. Following an attack of influenza in March, 1899, the severe dry cough continued through the summer months without improvement, accompanied by considerable sputum, worse in the mornings, until October, 1899,

when he became confined to the house, and for a time put himself under the care of another physician, whose diagnosis was that the man had diabetes.

Dec. 24, 1899, I again took charge of the case; confined to his bed; temperature 101° morning and 105° evening for several days running; pulse over 100; weight reduced to 135 pounds; very weak; cannot walk about; cannot sleep at night; delirious at height of fever; severe cough, and much thick, whitish sputum; examination of sputum by Health Department at City Hall shows presence of tubercle bacilli. December 31st seen with Dr. Goodno; physical examination shows right lung affected from apex downward; massive consolidation of right upper lobe, extending as low as fourth rib, anteriorly to bottom of lobe posteriorly; apex of right lower lobe also; moderate consolidation of left upper lobe; abundance of moist râles, especially in right upper lobe; no evidences of cavities of size, but probably slight breaking down; urine 16 pints in twenty-four hours; sp. gr. 10.28; examined several specimens, found no sugar, but excess of uric acid and oxalate of lime crystals; no nephritis. Prescribed thymol in capsules grs. ij. three times a day; arsenite of cinchona 2x. grs. ij three times a day; chloralamid grs. xv. at bedtime; did the best to produce sleep, as he could not sleep at all. Also used an inhaler to inhale beechwood creasote, chloroform and alcohol, mixed equal parts, inhaler to be used three times a day, and the homœopathic remedy as indicated by any special symptoms. This treatment was continued until January 20th, with patient still in bed and temperature ranging from 101 to $101\frac{1}{2}^{\circ}$ A.M., and $102\frac{1}{2}$ to $103\frac{1}{2}^{\circ}$ P.M.; patient continued weak, cough very distressing, much sputa; no gain in weight apparent; very thin; sputa again examined; shows tubercle bacilli.

January 26, 1900, commenced the use of anti-streptococcic serum and anti-tuberculin, each 2 c.c., a dose every day injected in the abdominal walls. This dose of 4 c.c. gave rise to no trouble, but when a syringe full of nearly 6 c.c. was used it caused a very sore-looking spot for two or three days.

The effect of the injection has worked on the fever, the cough and the general feelings of the patient.

26th.	12 M.	Temp.	102° .	4 c.c.	Combined serum.	Temp.	9 P.M.	99°
27th.	12 M.	"	101° .	4 c.c.	"	"	9 P.M.	$99\frac{2}{3}^{\circ}$
28th.	12 M.	"	$100\frac{1}{2}^{\circ}$.	4 c.c.	"	"	9 P.M.	$99\frac{4}{5}^{\circ}$
29th.	12 M.	"	100° .	4 c.c.	"	"	9 P.M.	$99\frac{3}{5}^{\circ}$
30th.	12 M.	"	100° .	4 c.c.	"	"	9 P.M.	99°
31st.	12 M.	"	99° .	4 c.c.	"	"	9 P.M.	99°

These injections were continued every day until February 28th, the temperature running from normal to 99° A.M., and from 99 to $99\frac{1}{2}^{\circ}$ 9 P.M. At this date microscopic examination

shows presence in sputa of tubercle bacilli. From the time the injections were commenced the improvement in the general condition of the patient was very marked, that is from the time his temperature remained below 100° . Strength greatly improved; could sleep at night without the hypnotic; improved in flesh; soon able to be up.

February 21st, he sits out on a third-story flat, sunny exposure, for an hour or more when it is not storming, regardless of low temperature; well wrapped up he does not suffer from the cold, and no ill effects have been observed from the exposure; his appetite has greatly improved, and he sleeps well all night; weight, 155 pounds; cough much less, and sputa almost nothing.

Dr. Goodno: Physical examination lungs, February 21st; râles almost disappeared; dullness greatly diminished.

Since February 28th he has received an injection of 4 c.c. every other day either of the mixed serums, or on one day the anti-streptococcic, and on the other day the anti-tuberculin, with no difference that I could observe in regard to their action, except that on the days the anti-streptococci was used the temperature was less likely to rise to $99\frac{3}{4}^{\circ}$ than on the other days. With the exception of a cold, which raised the temperature to 100° evenings for one week, the patient has progressed in health and strength, increase of weight being marked, April 4th, 161 pounds; goes out every day, and walks considerable distances, but examination of sputa, when we can get any, says presence of tubercle bacilli, and there is considerable sweat some nights.

The dose of serum used in this case is much smaller than the regular dose, but from its frequency seems to exert a marked influence on the temperature and general feeling of the patient. He now sits out in Fairmount Park part of day when weather is fit, south of Strawberry hill, where there are a number of pine trees.

SECALE CORNUTUM IN DIABETES MELLITUS.

BY SARAT CHANDRA GHOSE, MIDNAPORE, BENGAL.

I ADMINISTERED secale cor. in several cases of diabetes mellitus, and derived unexpected success. The history of one case was published in the August number of the *Homœopathic World*. I have thus come to the conclusion that secale cor. will prove an excellent remedy for that malady.

I append below some personal reminiscences of several cases.

CASE I.—Babu Kali Prassanno Ray; aged 45; was suffering from diabetes mellitus for the last 7 years. No medicine could cure the malady. I marked the following symptoms in him: Abundant sugar in the urine was present; great thirst existed; the patient hankered after cold drinks, which remained heavy on the stomach; emaciation and paleness of skin were noticed; extreme prostration was present; intense coldness of knees; the patient was very restless. I prescribed *secale cor.* 6x, and the patient came round within a month.

CASE II.—Babu S. C. Ghosal; aged 51; had diabetes mellitus. I detected the following symptoms:

Mind: Forgetfulness was present; he could not concentrate his mind on any subject.

Urine: Abundance of sugar in the urine; constant urging, with pain in the neck of bladder; pale-yellow urine.

Mouth: Dryness of mouth; sticky, frothy saliva; excessive thirst.

I prescribed *secale cor.* 6x, and the patient was cured by it.

CASE III.—Babu P. C. Ray; a zemindar; has been suffering from diabetes mellitus for the last 11 years, with divers troublesome complications. He was reduced to a mere skeleton. The following symptoms hovered about him;

Mind: Anxiety and fearfulness were present.

Sensorium: Giddiness and vertigo were present.

Eye: Pressure in the eyes was marked.

Ears: Hearing was indistinct.

Nose: Dryness of the nose was present; nose stopped-up, cannot breathe.

Face: Pale, earthy complexion; heat and burning of the face, with red cheeks.

Mouth: Dryness of mouth.

Desires: Hunger, even after meal; desire for water.

Stomach: Empty sensation in the pit of the stomach.

Stool: Disposition to constipation; the stools are hard and difficult.

Urine: Violent urging after urinating; pale urine, with a gelatinous sediment; pains in the hips while urinating.

Cough: Short, dry cough was present.

Pulse: Slow, weak pulse.

Sensations: Great lassitude, increased by any mental occupation. I prescribed *secale cor.* 6x. He was all right within two months.

CASE IV.—Babu M. N. Bhattacharjee, M.A., B.L.; aged 45; was suffering from diabetes mellitus. He had also been suffering from dyspepsia and gout for a long time. It will not be uninteresting if I deal shortly with his other ailments. At first he was attacked with gout, which confined him to bed.

During the last five years he tried all sorts of allopathic remedies, and with each kind the symptoms appeared to be aggravated. His attacks, which at first had been slight and came on infrequently, rapidly multiplied themselves, and appeared to be much more violent and agonizing. The sufferer had seen his system of treatment changed several times, and his weak body had, in fact, become a mere laboratory for the experiments of competing nostrums. At first he was bled copiously, but this process did not bring any good. He was then drenched with purgatives, and afterwards the doctors crammed him with innumerable remedial agents, but all proved to be totally ineffectual. The draining away of his blood and the weakening of his already weak body by purgatives exerted a deleterious influence upon his constitution, and the eventual consequence was that his ailment became chronic. Local treatment was no more efficacious. Leeches left his joints in a state of painful stiffness. Opium only aggravated his seizures, and blisters brought on painful ulcerations. As the paroxysms of his pain became more acute, heartrending groans and cries broke from his lips in quick succession.

He was suffering from gout, diabetes and dyspepsia when I was called in to see him. The most prominent symptoms were the following:

Mind: Absence of mind was present, and the patient always thought of committing suicide.

Inner head: Headache came on occasionally from the slightest chagrin.

Eyes: Profuse acrid lachrymation existed.

Nose: Puffiness of nose.

Face: Pale, sunken face.

Tongue: Taste was bitter.

Mouth: Mouth dry, with excessive thirst.

Desires: He felt hungry, but had no appetite.

Nausea: Nausea appeared after eating, especially at night.

Abdomen: Flatulent colic at night; burning in abdomen and cold feeling in the back.

Hypochondria: Burning and acute pains in hepatic region.

Stomach: Violent pressure in stomach, as from a heavy load, and burning in stomach.

Urine: Urine was pale and watery, and passed too frequently; urinary deposits looked like white cheese; increased quantity of urine.

Breathing: Slow.

Heart and Pulse: Palpitation came on oftener at night, with slow, intermittent pulse.

Limbs in General: Great lassitude and trembling of limbs

were present; cramps in the hands and toes appeared occasionally.

Nerves: Considerable prostration.

Skin: Was always dry.

Temperament: The patient was very irritable and nervous. In this case *secale cor.* 6x acted like magic in relieving the complaints.

CASE V.—A gentleman suffering from diabetes mellitus. He felt feverish in the evening. The temperature was found to be 102° in the evening. I marked the following symptoms:

Mind: Gloominess and disinclination to work.

Sensorium: Vertigo was present.

Eyes: Dryness of the eyes was present.

Face: Pale, earthy complexion.

Tongue: The taste was bitter, and the tongue was dry and enveloped with a black coating.

Gums: Readily bleeding gums.

Desires: Canine hunger, even after eating.

Stool: Constipation; stool tenacious and hard.

Urine: Enormous quantities of urine were voided daily, with excessive lassitude and prostration, and the urine contained sugar and albumin, and was dark-red and of high specific gravity.

Male Sexual Organs: Sexual power and desire were totally gone.

Heart: Palpitation of the heart was present.

Pulse: Small and intermittent.

Fever: Chill appeared in the evening, with great thirst. All the stages were not marked.

The patient was placed under my treatment on the 6th of January, 1899. Prescribed *syzygium jam.*

January 6th. Did not feel well; had an uncomfortable sleep; passed a large quantity of urine; specific gravity, 1045; excessive sugar; temperature, 102°.

January 10th. The condition of the patient no better than before.

January 11th. Prescribed *secale cor.*

Felt much better; had an easy sleep; amount of urine voided in twenty-four hours, 94 ounces; specific gravity, 1042; much sugar; fever was present.

January 20th. No fever; total amount of urine passed in twenty-four hours, 70 ounces; sugar still great; specific gravity, 1035.

January 30th. Total amount of urine, 60 ounces; specific gravity, 1028; sugar, a trace.

February 6th. Amount of urine, 55 ounces; specific gravity, 1024; no sugar.

February 16th. Amount of urine, 50 ounces; specific gravity, 1020; no sugar.

February 22d. Amount of urine, 44 ounces; specific gravity, 1018; no sugar.

February 28th. Amount of urine, 40 ounces; specific gravity, 1014; no sugar.

The patient was perfectly cured by the administration of *secale cor.* The success of these cases will throw a clear light on the fact that *secale cor.* will prove an excellent remedy for both diabetes mellitus and diabetes insipidus.

DIAGNOSIS OF GONORRHŒA OF THE EXTERNAL GENERATIVE ORGANS OF THE FEMALE.

BY WOODWARD D. CARTER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Phila., May 10, 1900.)

OF all diseases which affect the external generative organs of the female, the one under consideration is perhaps the most difficult of diagnosis, and certainly yields the least satisfaction in its treatment.

It is rare for a case of gonorrhœa to be seen in the acute stage. Ample authority can be given for this statement by experienced observers both in this country and Europe. Most cases come under observation after a period of several weeks, or even months, and by that time the gonococci have so firmly established themselves in the deeper tissues as to render their eradication by other than surgical means well nigh impossible.

The alarm and anxiety caused in the male sex by the appearance of a discharge from the urethra does not awaken the same fears in the mind of the female who is afflicted by a like condition.

Most women are accustomed to the presence of a leucorrhœal discharge of more or less severity. An increase of this flow, therefore, does not excite their attention until the symptoms become so distressing as to show the necessity of medical aid.

Should the condition be the result of illegitimate intercourse, motives of concealment will cause further delay, thereby intensifying the patient's sufferings. In the case of prostitutes, however, this is not the rule. Such women are quick to seek

medical advice for any unusual condition affecting their generative organs.

A typical case of acute gonorrhœa will exhibit the following symptoms: An urethral meatus, vestibule, nymphæ and ducts of the vulvo-vaginal glands in a high state of inflammation, bathed in pus, painful and sensitive to touch, and the act of urination attended by severe pain. The mucous membrane of the lower half of the meatus is swollen and everted, and early in the progress of the disease is changed from its pink to deep red. The ducts of the vestibule, from being almost invisible in their normal state, now stand out prominently on the surface of the mucous membrane, and their color is deepened many shades. If we inspect the vulvo-vaginal glands and their ducts, we will find in the first few days of the disease that they are tender to the touch, increased in size, and their normal secretion, which is colorless mucus, changed to muco-pus. The mouths of the ducts are pouting and of a deep-red color, and the mucous membrane surrounding the ducts for about an eighth of an inch in diameter tinged with the same hue. If a drop of this pus be placed under the microscope, and search made for the gonococcus, it will usually be found in the early stages of the disease.

The claim has been made that the vaginal mucous membrane is not susceptible to the action of the gonococcus. If we examine it closely we will note that, whereas in healthy condition the follicles in the vaginal mucous membrane, being sparsely distributed over the vaginal wall, are not readily visible to the naked eye, they can now be readily traced as minute angry red spots not larger than the head of a pin, which give forth a dirty grayish-colored secretion.

The structural arrangement of the anatomy of the external generative organs of the female, with its numerous folds of mucous membranes and generous supply of glandular bodies, affords every facility for the secretion and development of gonococci.

This knowledge has led Dudley to remark that "he who would abort a gonorrhœa of the female must be there with his antidote before the septic intercourse takes place."

As above outlined, the diagnosis of gonorrhœa is comparatively easily made, but, as stated before, acute cases rarely

present themselves for examination. Most usually there is an absence of many prominent symptoms. Sometimes the swelling and the greater portion of pain has subsided spontaneously. The vulvo-vaginal glands and the urethra may show but slight pathological changes, and a careful search of the discharges may reveal no gonococci. Upon what symptoms, then, can we base a correct diagnosis?

The most conclusive evidence, of course, is the finding of gonococci in the discharges. But in the absence of gonococci can a correct diagnosis be made? I think we are justified in answering this question in the affirmative. Let us now examine the various points of infection in the order of their greatest importance, to the end that we shall find enough evidence of gonorrhœa to make out a clear case without the presence of gonococci in the discharges.

The meatus urinarius will be found pouting, its mucous membrane changed in character, its appearance resembling an urethral caruncle. The ducts of the glands of the vestibule reveal dark-red spots, which mark the former dwelling-place of the gonococcus. The introduction of a finger into the vagina and its careful withdrawal along the course of the urethra will sometimes milk out a drop of pus. Should this occur, it is almost pathognomonic of gonorrhœa.

Condylomata are common, and often spread over the surface of the mucous membrane from the vulva to the cervix. These almost never occur with any other condition.

The vulvo-vaginal glands next attract the examining eye and finger. The ducts are deep red and congested. The glands themselves are swollen, and often remain so after all other signs of gonorrhœa have disappeared. The reason for this is explained by Sanger thus: "In many cases of gonorrhœa the disease has not ceased with the disappearance of the gonococcus, and the inflammatory process consequent upon the entrance of the gonococcus into the tissues may persist after the gonococcus has disappeared as an apparently inflammatory process that ultimately leads to scar tissue, and also as an apparently recurring diseased condition in the form of an acute exacerbation of the existing chronic inflammation." To these existing chronic pathological conditions has been applied the term "residual gonorrhœa," or "latent gonorrhœa."

Investigation of the relative occurrence of the gonococcus in the structures attacked by gonorrhœa show the urethra to be more frequently involved.

Whitbe reports 228 cases of gonorrhœa in which gonococci were found 16 times in the vaginal secretion, and 42 times in the urethra.

Schultze found gonococci in 174 patients 104 times; 78 times in the urethra, 81 in the cervix, and 14 in the vulvo-vaginal glands.

Baum in 74 cases found gonococci 73 times in the urethra.

Steinschneider found the urethra affected in 47 per cent., Horan in 75 per cent., and Baum in 90 per cent.

Brose and Schiller, after a careful examination of 271 cases of gonorrhœa, making about 1500 microscopical preparations for gonococci, state that "Gonococci were always found in acute gonorrhœa of the female, but the proof of the gonococci is not, as a rule, necessary for the diagnosis of gonorrhœa. The combination of various diseases of various parts of the female, as vulvitis and urethritis, urethritis and cervical catarrh, urethritis and vaginitis, urethritis, cervical catarrh and diseased adnexa especially favor the diagnosis of gonorrhœa. Neisser's dictum that in all cases of gonorrhœa in the female the diagnosis can only be made by the proof of the presence of the gonococci is not correct, and may lead to a mistaken diagnosis in many cases. The diagnosis of chronic gonorrhœa in the female is based, before all else, on the presence of disease at the same time in different parts of the genital tract. Chronic urethritis is the surest sign of gonorrhœa. The other affections of the vestibule and vagina above are uncertain. Positive as is the presence of the gonococci in diagnosing gonorrhœa, the absence of them is not equally negative. The main dependence of diagnosis must rest on the clinical symptoms."

SHOULD CASES OF FOLLICULAR TONSILLITIS BE ISOLATED?—Dr. Singert asserts that they should be isolated, for of late many cases of serious pyæmic and septic affections have been reported following this seemingly simple disease, which has been noted to be contagious and with an average stage of incubation of four days. Children, therefore, should be kept from school that length of time.—*Wiener Medicinische Presse*, No. 52, 1899.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE ENDOWMENT OF OUR MEDICAL COLLEGES.

IN all advance movements we naturally find a large body of enthusiasts who, in their advocacy of new measures, are apt to belittle the old and to become extremists. While such enthusiasts are necessary to real progress, they can only be regarded as advance guides to point out the direction in which the conservative element is to proceed, more slowly, it is true, but more safely.

In the remodelling of medical instruction in the present time we have seen and heard much of the extreme and supreme importance of laboratory and clinical work as opposed to didactic lectures. Many there have been and some there still are who would relegate the didactic lecture to an entirely subordinate position, and others who would even abolish it altogether. Some would have it merely as an adjunct to the practical work, while others would change it into recitation or quiz from an established text-book. These are extreme views, and we trust they may never gain universal acceptance.

That the advance in medical science and art should have demanded and brought about a reaction against the almost purely didactic and very unpractical mode prevailing in medical schools a few decades ago was but natural, and that this reaction should have been excessive was equally to be expected. The call for more and more clinical instruction has become louder and louder, and the demand for laboratory work and corresponding laboratories more and more insistent, until at the present time the standing of a medical college has come to depend upon the number of clinics and laboratories enrolled in its curriculum. The didactic courses are now tolerated by many only provided they have a laboratory attached.

While fully in accord with this demand for practical and scientific work on the part of the student, we are convinced that the didactic lecture holds a position and possesses advantages which nothing else in the curriculum can supplant or render superfluous. Apart from the influence exerted by the personal enthusiasm of the lecturer, an element of immense

importance in the imparting of knowledge, the didactic lecture affords the only means of presenting a subject in its entirety. Any one who has ever engaged in educational work, whether in school or college, must have been struck by the peculiar fragmentary character of the knowledge at first acquired. Just as, in the mental development of the infant, the facts of observation stand for a long time isolated, only gradually, in childhood, to be united by their intrinsic connections into conscious knowledge, so, in the later acquisition of more advanced truths, these latter are slow to be united into a generic unity which shall be within reach when needed and capable of being utilized. The laboratory and clinic present isolated facts, separate phases, as it were, of complex conditions, which in the didactic lecture are assigned their proper respective positions according to their relative importance as parts of a whole. Were it possible, with the time at command, even in a four years' course of medical instruction, to cover in laboratory and clinic the entire field of medical science, perhaps the natural method would be to finish and to summarize such practical work by didactic lectures, in which the results of actual experiment and observation would be grouped and presented as a whole, capable of being grasped, retained and assimilated. It is manifestly impossible to repeat in laboratory work and in the clinics all which lies at the foundation of the medical knowledge of the present day, and which has been the result of years and years of patient research and experiment. The so-called practical courses have to be, as they really are, more or less incomplete and fragmentary. The didactic courses, however, built upon the accumulated wisdom of the past in all departments, can offer a complete and organized presentation of a subject, and should, therefore, under present conditions precede the practical work, which then comes to occupy its legitimate position as a means of verifying and impressing upon the mind already known facts. This does not apply, of course, to original research, which has no place in the curriculum of a medical college.

With this recognition of the natural and logical relation between the didactic and practical courses, we are willing to grant that the demand for increased laboratories as adjuncts to the various didactic chairs is both justified and imperative.

In his address as President before the American Medical Association, W. W. Keen, M.D., speaking on this subject, said:

"In the modern, fully equipped medical school, no less than thirteen laboratories are needed, viz., that of anatomy, of histology, of embryology, of physiology, of chemistry, of physiological chemistry, of pharmacy, of pharmacology, of practical obstetrics, of surgery, of morbid anatomy, of bacteriology, and of hygiene."

To equip and keep up these various laboratories requires a great amount of money. This cannot be derived from the students' fees, which, in consequence of the lengthened period of study, will bear no further increase, and it should not be taken from the pockets of the instructors. It should be raised by the endowment of the colleges, or by the foundation of special laboratories in them by public spirited benefactors. Of the nearly \$80,000,000 donated to various institutions during the year 1899, but a small part fell to the share of the medical schools, and yet the requirements of these are greater than, and their merits surely as great as, those of the other recipients of these benefactions. Much can be done by physicians in this direction by presenting their cause to their wealthy patients with the same assiduity and persistence shown by their clerical brethren in presenting the wants and claims of the theological schools, five of which, during the year 1898, received endowments ranging from \$850,000 to \$1,369,000 each.

Our own Dr. W. B. Van Lennep, in his address to the Alumni of "Old Hahnemann," on occasion of their banquet on May 17th, said: "If I cannot tell you where to invest your money, I can at least show you where you can invest the money of your opulent clients. Invite them, induce them to erect monuments, in your name, if you please, or in their own, and that in institutions which have demonstrated that they have a right to live."

Speaking more particularly of the college with which he is personally connected, although his remarks are capable of general application to our homœopathic colleges, he forcibly presents the subject as follows:

"With an income limited by the students' fees it is out of the question for Hahnemann to acquire the services of a corps of men who shall give up active practice and devote their time and energy exclusively to scientific research and teaching. Clinical teachers are always available because the prestige and experience of the position are sufficient emoluments. The re-

sult is a course of study strong in the superstructure, and were it not for the unselfish devotion of a few, our house would surely be founded upon the sand. You can readily see, therefore, the rock-bottom necessary to make the course at Hahnemann an evenly-balanced and well-rounded whole. Besides fully-equipped, up-to-date laboratories to teach *in*, we must have endowed fundamental chairs to teach *with*; and by fundamental subjects I mean, for example, anatomy, physiology, histology, embryology, biology perhaps, although this, with botany and zoology, probably belong to the preparatory medical course; general and special pathology, bacteriology, blood study, general, perhaps, and certainly medical chemistry, hygiene, and, above all, experimental homœopathic *materia medica*."

We hope these representations from both sides of the house may bear fruit, and lead to a more generous recognition of the claims of the medical schools. The endowment of our medical colleges is a necessity, if they are to do all that is expected of them.

THE HAHNEMANN MONUMENT DEDICATION.

On Thursday afternoon, June 21, 1900, at 5 p.m., in the presence of the President of the United States and the members of the American Institute of Homœopathy, the monument to Hahnemann was unveiled and dedicated. The services consisted of music by the U. S. Marine Band, with Introduction by J. B. Gregg Custis, M.D.; Invocation by Rev. B. F. Bellinger, D.D.; Presentation by J. H. McClelland, M.D.; an inspiring Ode to Hahnemann, by Wm. Tod Helmuth, M.D., LL.D.; Reception and Presentation of the Monument to the Government in a masterful address, ringing with eloquence, by C. E. Walton, M.D., President of the A. I. H.; acceptance by the Government, Col. Theodore A. Bingham, U. S. A.; Oration by Hon. John Griggs, Attorney-General of the United States.

On an ideal summer's afternoon, in the loveliest section of the most beautiful city in the world, under delightfully auspicious circumstances, and in the presence of a vast concourse of people, a splendid monument of rare artistic conception and elegance, the creation of Niehaus, costing over seventy thousand dollars, was dedicated to the founder of Homœopathy, Samuel Christian Friedrich Hahnemann. The occasion carried to the fullest limit of success the unceasing efforts of Drs. J. H. McClelland and H. M. Smith, and all enjoyed the gratification of knowing that, before the procession had left its headquarters for the site of the monument, the last cent necessary to pay for the monument had been provided, twenty-eight thousand dollars having been collected during the past twelve months.

GLEANINGS.

INDICATIONS FOR TREATMENT IN ASTHMA.—Faulkner recommends the daily use of a system of gymnastics calculated to exercise the respiratory muscles. In addition, to prevent the return of the paroxysms, the chief indications are for:

1. Removal of all exciting causes.
2. Removal of all toxic influences, rheumatic, gouty, renal, malarial, irritating plants (ragweed, goldenrod, ailanthus, honeysuckle), irritating dust (hay, feathers, Chinese matting, ipecac), irritating animal odors (horses, dogs, cats, rabbits), acid fumes, the atmosphere of close, warm rooms.
3. Restoration of general good physiologic conditions of digestion, respiration, circulation, nervous system, cutaneous surface.
4. Removal of reflex irritations, nasal, rectal, uterine.
5. Relief of bronchial hyperæmia, bronchitis.
6. Repair of emphysema.
7. Climatic suggestions.

Many well-known clinical facts pertaining to the nature of asthma are neglected in its treatment. Asthmatics should wear woolen undergarments throughout the year. The skin of asthmatics being generally atonic requires stimulation, one good means being salt-baths and friction. It is also particularly important that the digestive organs be put in proper condition. Iodids and hypophosphites have given him good results in bronchitis. In emphysema the best results have been from the Waldenburg apparatus. In regard to climate he knows of no rule—what suits one patient cannot be depended on for another.—*Phila. Med. Journal*, June 2, 1900.

F. Mortimer Lawrence, M.D.

CONDITIONS SIMULATING APPENDICITIS.—Janeway, enumerating the conditions which may be mistaken for appendicitis, directs especial attention to neuralgia in that region, to renal colic, particularly when protracted and febrile; to cholecystitis, and to perforation of duodenal or other ulcers of the gastro-intestinal. He has seen a case of carcinoma diagnosed appendicitis and operation arranged; the patient died before operation. He has seen a similar blunder in several cases of renal colic. Typhoid fever is not unlikely to resemble appendicitis, and tonsillitis, with severe pains in the iliac region, has been called appendicitis. Diseases of the internal genitalia may simulate the disease.—*Med. Record*, May 26, 1900.

F. Mortimer Lawrence, M.D.

SYMPTOMS IN DISORDERS OF THE STOMACH.—Hews records the chemical analyses of 250 cases of disorder of the stomach treated in his clinics at the Massachusetts General Hospital. Eighty five of these showed evidence of definite organic disease; carcinoma, ulcer, etc. In the remaining 165, chemical abnormality was the only objective sign. A comparative study of the

symptomatologic subjective signs and the chemical findings in these 165 cases revealed the following important facts in regard to the symptoms :

1. One symptom, distress, was present in practically all the cases, and one symptomatology, distress plus a desire to raise gas or actual eructation, was present in 80 per cent. of all cases, including many cases of each variety of acid condition.

2. This symptomatology was the total symptomatology in 20 cases of hyperchlorhydria, in 41 cases of normal acidity, and in 14 cases of hypochlorhydria, nearly one-half of all cases.

3. In 27 cases of hyperacidity additional symptoms, as heartburn, pyrosis, were added to this common symptomatology.

The writer concludes that these common symptoms, distress and eructation, represent the natural reactive manifestations of the stomach when that organ is disturbed from any cause whatever. Thus, these symptoms are present in all cases of gastric disturbance regardless of cause. When the affection is severe other symptoms, as vomiting, may be imposed. Where the cause is an irritant, as an excess of acid, special symptoms, as the pyrosis, indicative of this special cause, may be added.

Therefore, subjective symptoms are no guide to the chemical conditions or to the actual objective nature of stomach disturbance.—*Phila. Med. Jour.*, May 26, 1900.

F. Mortimer Lawrence, M.D.

ARTIFICIAL NAUHEIM BATHS.—Mayer asserts that Nauheim baths may be prepared at home, and the results from their use, if properly carried out, are quite the same as those obtained at Nauheim. He recommends a mixture composed of 30 pounds of sea salt, 10 ounces of potassium chloride, 30 ounces of calcium chloride and 8 ounces of magnesium chloride, well mixed and kept free from moisture. Three pounds of this mixture is to be added to 30 gallons of water, and the quantity gradually increased until 5 pounds are used. The temperature at first should be 95° and later reduced to 85°. The duration of the bath, at first five minutes, should be increased gradually to fifteen or twenty minutes. The treatment should be continued, as a rule, over several months.

Mayer investigated the effect of the artificial bath upon his own person, and found that it caused a reduction of the pulse rate from 76 to 62, and although his cardiac and liver dullness were normal, the cardiac dullness decreased nearly half an inch and the liver dullness somewhat more.—*Med. Record*, May, 26, 1900.

F. Mortimer Lawrence, M.D.

SENILE BRONCHITIS AND ITS TREATMENT.—Dr. Reynold W. Wilcox, of New York, in a paper read before the Buffalo Academy of Medicine, noted that one-third of the cases of death in the aged were due to senile bronchitis. Tissue changes in old age were due to three factors : (a) atrophy of tissue, (b) infiltration of tissue, (c) abnormal development of connective tissue. The immobility of the chest in the aged, and the change in the position of the lungs in the chest were to be considered, among others. The sequence of bronchorrhœa, bronchitis, pneumonia and tuberculosis, their symptoms and diagnosis, were dwelt upon, and the essayist noted the difficulty of distinguishing clinically senile pneumonia from tuberculosis.

In the treatment of senile bronchitis, belladonna and the expectorants

useful in childhood were of little value. The two drugs of first rank were strychnia and ammonium carbonate. To disinfect sputum, preparations of creasote were to be used. Opium was an objectionable drug. Inhalations of eucalyptol were of value. Massage brings about brilliant results and increases the air capacity of the lungs. A warm, dry atmosphere, wool next to the skin, the bowels regulated by vegetable purgatives, are requisite for proper conduct of a case. Alcohol should be avoided, as also hearty evening meals.

In the ensuing discussion Dr. Cary spoke on one point which he considered had been overlooked—*i.e.*, the eliminative function of the lung in old age. He considered the cause of senile bronchitis the elimination of morbid products by the lung and a consequent toxic disorder. The lung in the aged takes on the work of broken-down kidneys. Consequently, in the treatment of such a condition, baths and purgatives were indicated, and activity of all eliminative organs was desirable.

Dr. Stockton stated that senile bronchitis was due to similar changes going on in the skin, kidneys and digestive apparatus. He agreed with Dr. Cary in his view of the eliminative function of the lung, and regarded overwork as a cause of senile bronchitis. The blood is more toxic in the aged, and senile bronchitis is a disease of toxæmia. The treatment consists of preserving the energy of the kidneys, the elasticity of the skin, the power of the heart and the contractility of the blood-vessels. The hot-air vapor-bath was one of the foremost therapeutic measures.

Dr. Allen Jones referred to the great value of the iodides.

Dr. Rochester took into consideration two forms of senile bronchitis: (a) serous expectoration, or little or no expectoration; (b) muco-purulent expectoration. The general treatment in these two classes of cases is the same, but the direct treatment is different. In dry cough (the serous form) the iodides are useful, while in the second class the balsams are better, with the addition of copaiba inhalations.

Dr. H. R. Hopkins mentioned two classes of cases: (a) when the excretion of urea is diminished; (b) when the skin and bowels did not properly exercise their functions. As for drugs, hydriodic acid is the best means of giving the iodid. Next in value is the iodid of sodium. Apocynum increases the kidney function, and euonymin was excellent for a tired liver.—*Buffalo Med. Journal*, May, 1900.

F. Mortimer Lawrence, M.D.

DIFFERENTIAL DIAGNOSIS OF A DISEASE OF THE PLEURA FROM ONE OF THE LIVER.—Prof. A. Cardarelli, of Naples, calls attention to the difficulty of diagnosing an enlargement of the liver from an effusion into the pleural cavity. If the finger, on percussion, detects a wooden flatness, then there is no pleuritic exudate present, except that the *whole* pleural cavity be full. Look at the intercostal spaces. If they be narrow, and the floating ribs be elevated, then the liver only is enlarged. In pleural effusion they are widened. Place the hand on the opposite part of the chest and strike a blow with the tips of the fingers of the other hand. If an impulse be transmitted, then a liver affection is present. A capital symptom of liver disturbances is a pain in the shoulder, and one to which he emphasizes decidedly; it is never observed in pleural, but, *on the contrary, in liver diseases*. These signs hold in chronic cases.

But supposing that the patient has high fever and violent pains? There is dullness at the base of the thorax. What is it? A pleural effusion, empyema, or a subphrenic abscess? Œdema of this region points rather to abscess. If, with high and continuous fever, the line of dullness does not rise, rather abscess than empyema is present, for with this condition in pleurisy the exudate rapidly increases. Exploratory puncture, though useful, may deceive. If it be done posteriorly, and a limpid serum be withdrawn, then a pleuritis is diagnosed. The patient undergoes thoracocentesis and experiences no relief. He relapses, and after death the autopsy reveals an abscess of the liver. There was a pleuritis associated with the liver disease. Make the punctures in the axilla or anteriorly, and not at the highest, but at the lowest possible level of the liquid. With an empyema the outflowing liquid is not modified by the respiration, but if it be subphrenic the jet is increased by lowering of the diaphragm. The reason is plain: the descent of the diaphragm compresses the liquid.—*La Settimana Medica*, No. 4, 1899.

Frank H. Pritchard, M.D.

CLINICAL DIAGNOSIS OF CERTAIN FORMS OF ALBUMINURIC BRONCHITIS AND PULMONARY TUBERCULOSIS.—Drs. E. Hirtz and P. Merklen call attention to the difficult differential diagnosis of those cases with chronic kidney diseases where there appear, as complications, attacks of bronchitis of varying degree and intensity from phthisical subjects, with albuminuria. The differentiation is often far from easy. Of albuminuric bronchitis one sign is pathognomonic: the varying site of the local disease, now the apex, then the base of the lung. The apical localization is to be differentiated from tuberculosis of the lungs. Three forms of albuminuric bronchitis are to be distinguished. If it appear as a *broncho-pneumonia* it is scarcely to be confused. Different is it if it be noted as a *localized œdema of the lungs*. If the patient be seen for the first time there will be found in the apex numerous fine and crepitating râles, with a weakened respiratory murmur, but the respiration is *not* bronchial, or, at all events, the respiratory and vesicular murmur is little altered. The voice is transmitted normally; and, what is most important, the sounds on percussion, as well as voice-transmission, are unaltered. The subjective symptoms are important; the patient coughs but little, generally does not expectorate, and the dyspnoea has a specific character, appears periodically independently of motion, and most often *at night*. In general there is a great lack of relation between the auscultatory findings and the symptoms. The signs of albuminuric bronchitis are capricious and variable, remaining for a longer or a shorter time in a part of the lungs, to reappear in another, while in tuberculosis the lesions *do not wander nor vary*. Bacteriological examination and inoculation of the sputa are also of value in differentiating.

A third form, *albuminuric bronchitis*, is accompanied by crepitating, more or less moist râles, with foamy mucus, or muco-purulent expectoration, which is sometimes sanguinolent, but which is different from the yellow and scanty sputa of phthisis. No dullness nor alteration of respiration. The symptoms disappear after a while, even in a short time.—*Hospitalstidende*, No. 3, 1899.

Frank H. Pritchard, M.D.

JOINT-MANIFESTATIONS IN "BLEEDERS."—Dr. Poul K. Faber, of Copenhagen, observed a "bleeder" of twenty years, who since his sixth year had been subject to frequently recurring collections of fluid in various joints which

would appear spontaneously or from trauma. They would remain thus for several weeks, be afebrile, with severe pain and loss of function. While in the hospital there was fluid in both knee-joints, and crepitation could be felt. No bony changes were to be noted radioscopically.

Pathologically these joint-manifestations are not rheumatic, but due to blood in the articulation, accompanied by a state of chronic inflammation. From twenty-three cases he describes their peculiarities. The knee-joints are especially liable to be attacked, though usually it is polyarticular, with trauma and sprain as causes, though spontaneous appearance is most general. The joint is suddenly and violently filled with blood, the distention reaching its maximum in one-half to one day. The overlying skin is pale or mottled with ecchymoses, the pains violent, and the joint sensitive to motion and contact. At times the subjective phenomena are milder. Appropriate treatment brings about restoration in several days to weeks. The later attacks, coming on at irregular intervals, are less severe. The joint at first may resume its former functionability, but later attacks are prone to bring about a chronic inflammatory state, with destruction of the cartilages and capsule, thickening of the synovial membrane, and ankylosis and looseness of the joint. No abscesses nor fistulæ form. At first the joint is filled with blood, partly fluid and partly coagulated, the thickened capsule being impregnated with coloring-matter of the blood. Later the articular cavity is obliterated by new formation of bone and cartilage, as well as adhesions, and thus the similarity to arthritis deformans is striking. Under these circumstances a diagnosis may be very difficult, where the joint-changes set in before the hæmophilia becomes manifest, or where the articular affection is complicated with other diseases, as tuberculosis. Operative measures finally are *wholly contra-indicated*, for many eminent surgeons have had sad and regretful experiences in these cases when misunderstood.—*Nordiskt Medicinskt Arkiv*, Hæft 1, 1900.

Frank H. Pritchard, M.D.

A CASE OF ACUTE LYMPHADENIA.—Dr. Hirtz recently communicated to the Société des Hôpitaux the case of a man of 21 years who had died of acute lymphadenia. It had begun last October by progressive weakness, headache, emaciation, shortness of breath on the least movement, etc. The disease assumed the splenic type, that organ becoming very large, while the axillary, inguinal and other lymph-glands remained indolent and moderately swollen. The patient very rapidly became worse, and died towards the end of November, in consequence of repeated and profuse epistaxis. Death possibly might have been accelerated by a secondary infection due to suppuration of the nasal fossæ. Examination of the blood at different intervals revealed a notable diminution of the red-corpuscles and a considerable increase of the white ones (112,350). The increase concerned only the large and small lymphocytes; the condition, therefore, was a lymphocythæmia.—*La Semaine Médicale*, No. 12, 1900.

Frank H. Pritchard, M.D.

A CASE OF PRIMARY DOUBLE INFLAMMATION OF THE SUPRARENAL CAPSULES.—Dr. W. Janowski observed a married woman of 25 years who, in the seventh month of pregnancy, three days before seen had been seized with:

Chills, repeated vomiting and violent pains in the back, more pronounced on the right side. There was no fever, pulse of small calibre and 120; respi-

ration accelerated (48); skin dry and yellowish; heart-sounds very clear, but quite *muffled*. The region over the right kidney very sensitive, swollen, and slightly prominent. The urine was dark, without biliary pigment, albumin, sugar, blood, or other sediments.

A perinephric abscess was diagnosed, and an operation revealed pus in the upper part of the right kidney between its adipose and fibrous coats. The following day the patient aborted and died. The necropsy revealed a suppuration of both suprarenal capsules, only a thick envelope remaining. On the right side the process had extended to the kidney, and notably to the intermediate space of the two capsules. The left kidney as well as its perinephric envelope were not affected. No other lesions in other organs, therefore the inflammation must be regarded as primary, a rare condition.

The writer points out three symptoms which might facilitate the diagnosis: (1) Sensitiveness of the lower part of the thorax, which is not met with in perinephric abscess; (2) The muffled sounds of the heart, that organ having considerable influence on the blood pressure; (3) The almost black color of the urine, due to a considerable quantity of urinary pigments.—*Przegląd Chirurgiczny*, Tom iv., Zeszyt 3, 1900.

Frank H. Pritchard, M.D.

VESICAL ASTHMA—A CONTRIBUTION TO THE ASTHMA OF OLD MEN.—Dr. Pawinski, with a basis of five cases, points out the possibility of asthma in old men being dependent on incomplete evacuation of the bladder—vesical asthma. These patients are usually in an advanced age, with vascular lesions, myocarditis, valvular affections, kidney diseases, or very often with hypertrophy of the prostate. The urine is passed frequently and abundantly, particularly at night, and is clear. It may at times contain traces of albumin or casts. Thus one may think that the bladder is wholly evacuated, while on examination it will be found to form a tumor. The dyspnoea may resemble the form of an angina pectoris, though it may assume no definite type, and never resembles bronchial asthma. Heart stimulants and narcotics are usually inefficacious, while the use of the catheter causes the attack to cease. Repeated systematically, the seizures may be prevented. He regards the asthma as due to autointoxication. Guyon has called attention to dyspepsia, long-lasting and resistant to treatment, being dependent on retention of urine, which would only cease after catheterization. The writer has rather observed *asthma* in such cases. Normally, the vesical mucous membrane is tolerably resistant to toxines, but in these subjects it is altered and capable of absorbing noxious agents while the kidneys not functioning well are unable to eliminate them. These toxines act perniciously upon the brain and excite the vaso-motor, respiratory and cardiac centres. The prognosis in these cases is favorable, provided that the general condition is yet good, and catheterization does not give rise to signs of infection or autointoxication, as may happen in exhausted subjects.—*Przegląd Chirurgiczny*, Tom iv., Zeszyt 3, 1900.

Frank H. Pritchard, M.D.

COCAINE IN HERPES ZOSTER.—Dr. Bleuler has obtained excellent results in a number of cases of herpes zoster by local application of an ointment containing 1 per cent. of cocaine in equal parts of vaseline and lanoline. It is rubbed into the affected region and held in place by a proper dressing.—*Literatur-Beilage der Deutschen Medicinischen Wochenschrift*, No. 12, 1900.

Frank H. Pritchard, M.D.

TWO CASES OF ANOMALOUS SPINOUS PROCESS OF SEVENTH CERVICAL VERTEBRA ARTICULATING WITH THE SCAPULA.—Wilson and Rugh (Philadelphia) place on record these two interesting cases. The first case was that of a girl, seven years of age, who applied for treatment for the relief of a supposed injury to the shoulder at birth. Her general appearance was that of one affected with torticollis. On closer examination the seeming lateral deviation of the head was found to be due to an elevation of the shoulder, and this, in turn, was readily observed to be firmly ankylosed to the spine. There was inability to stretch the arm forward and directly upward. An operation was undertaken, and the following interesting condition found. The scapula and the seventh cervical vertebra were united by a piece of bone one and a quarter inches long, and one and an eighth inches in circumference. The cervical attachment was bony, the scapular fibrous in character and covered with articular cartilage. This piece of bone was removed, and the shoulder returned to its normal condition. The other case was exactly similar in all its details, only the patient was much older, sixteen years of age. In both cases the deformity was on the left side. The piece of bone removed from the elder girl was two inches long and one and three-quarter inches in circumference.

“The characteristics of both specimens render justifiable the theory that there has been an extra centre of ossification for a spinous process, and this has been pushed or placed beyond the normal centre for the process of the seventh cervical vertebra, though this does not account for the fact that in both cases there was firm articulation with the scapula.”—*Annals of Surgery*, April, 1900.

Gustave A. Van Lennep, M.D.

REPORT OF A CASE OF RECOVERY AFTER LIGATION OF THE FIRST PORTION OF THE RIGHT SUBCLAVIAN ARTERY FOR ANEURISM OF THE THIRD PORTION.—Halstead (Chicago) ligated the first portion of the right subclavian for the cure of an aneurism about the size of a hen's egg, of the third portion, after the following method: A curved incision, with the convexity downward, was made, beginning just above the suprasternal notch and ending externally about two centimetres above the deltoid tubercle of the clavicle. This flap was turned up, and the sterno-mastoid, sterno-hyoid and sterno-thyroid muscles were divided across just above the clavicle, exposing the internal jugular vein and carotid artery. The lower part of the scalenus anticus muscle was then found by drawing the carotid artery, pneumogastric and recurrent laryngeal nerves inward, and the internal jugular and innominate veins outward. Close to the inner edge of the scalenus anticus the vertebral artery was located, with the thyroid axis three-eighths of an inch to the outer side. This was traced downward, leading to the subclavian. The sheath was opened just internal to the point of origin of the vertebral. In attempting to pass the ligature the posterior wall of the artery ruptured, necessitating a ligation some distance further down. In order to do this it was found necessary to resect the inner fragment of the clavicle, and with it the upper angle of the scapula.

The writer regards this as a necessary step in the operation, and would recommend it in all cases. Judging from the after history of this case, it does not interfere with the usefulness of the arm, the patient having “an almost perfect clavicle at the end of six weeks.” Gouchon's suggestion of

applying two or three noncontiguous absorbable ligatures was followed, they being tied sufficiently tight to occlude the vessel, but not tight enough to rupture the arterial wall. The wound healed kindly, and at the end of seven weeks the patient was well, with no radial pulse and no return of pulsation in the aneurism. This is the second case on record where the patient survived the operation of ligation of the first portion of the subclavian.—*Annals of Surgery*, May, 1900.

Gustave A. Van Lennep, M.D.

DISLOCATION AT THE SHOULDER COMPLICATED BY FRACTURE THROUGH THE ANATOMICAL NECK OF THE HUMERUS.—Brigham (San Francisco) reports the following case. A man was thrown from a wagon, sustaining an injury to the shoulder by striking heavily on the palm of the hand. A dislocation of the shoulder was recognized, and reduced under chloroform. Five months later there was a depression of three-quarters of an inch in width and two and a half inches in length just below the acromion. There was one inch shortening. A part of a sphere could be felt in the axilla, attached to the humerus, near the inner tuberosity. The shoulder-joint was opened by an incision along the inner border of the pectoralis major, and the head of the humerus was found detached from the shaft, displaced below the glenoid cavity, and held in position by a narrow band of callus to the inner side of the humerus. Its removal was accomplished without any difficulty, and gave a good result. (Fracture through the anatomical neck, complicating dislocation, is rare. Stinson, in his work published in 1899, says: "The fracture may occupy the anatomical or the surgical neck, or may extend through the tuberosities, or may be extensively comminuted. Of 68 cases collected by Thambayn the fracture in 14 was of the anatomical neck; in 2 of these reduction was effected. The upper fragment usually preserves its vitality and establishes new vascular connections. The two positive signs which the surgeon should spare no pains to recognize are the absence of the head of the humerus from its socket, which proves the dislocation, and its failure to share in movements communicated to the shaft, which proves the fracture.")—*Annals of Surgery*, May, 1900.

Gustave A. Van Lennep, M.D.

SURGERY IN THE PRESENCE OF SUGAR IN THE URINE.—Fisk (New York) says: "The great improvement in the perfection of surgical technique in the last decade has compelled a reconsideration of former surgical traditions, among which is the '*noli me tangere*' of those individuals who, suffering with surgical diseases, are so unfortunate as to have glycosuria too. The opinion is growing that, while such individuals are not good surgical subjects, nevertheless, with extreme care in the selection of cases and scrupulous perfection in surgical asepsis, they must not be denied the benefits of surgical relief."

Four cases are reported in which an operation was performed with the presence of sugar in the urine.

CASE I.—A carcinoma of the breast was removed from a woman, sixty-one years of age, after the method of Halsted. The patient had a feeble circulation, fatty heart, and 2.5 per cent. of sugar in the urine. Ether was the anæsthetic. The wound healed "per primam," with the exception of a small area, which was skin-grafted. A slight recurrence in the scar after two and a half years was removed under cocaine. Later a small ulcer in the

ciatrix, probably due to an injury, was excised under ether, along with a portion of the underlying rib. The wound healed, and the woman was alive fully four years from the time of the operation. There still existed 2.2 per cent. of sugar in the urine.

CASE II.—Operation of appendicectomy, during an acute attack, on a man fifty years of age, who had been a sufferer from diabetes mellitus for several years. The appendix was removed, and an abscess evacuated. The wound healed slowly by granulation. Five years later the man was living and engaged actively in business.

CASE III.—Man of seventy-five with diabetic gangrene of right foot. Urine showed 7.5 per cent. of sugar. Amputation was performed at middle of thigh. There was atheroma of the femoral artery. The wound healed by first intention. Three months after the operation the sugar had entirely disappeared. The subsequent history of this case is interesting. Eleven months from the time of operation, gangrene of the left foot supervened. The urine showed a trace of albumin but no sugar. Amputation at the thigh by long anterior and posterior flaps resulted in sloughing, and death in a few days. The femoral artery was found very calcareous. The noticeable change in the femoral artery, in this case, indicates the very important etiological part that arteriosclerosis has in diabetic gangrene.

CASE IV.—Man of sixty. Urine showed the presence of sugar to 1 per cent. Diabetic gangrene of the great toe of the right foot. Amputation through the thigh was advised but refused, and amputations of the toe requested by the patient. This was done, with the usual result, the wound showed no tendency to heal, but no extension took place into the foot. Gangrene of the left foot came on suddenly, which extended so rapidly that within four days the man died in a comatose state. In conclusion the writer states:

"The presence of glycosuria in those individuals who may have surgical diseases does not in itself constitute an absolute contra-indication to any and all surgical relief. Very great judgment must be exercised in the selection of cases, in the determination of the kind and extent of the operation to be performed, and the strictest surgical asepsis must be rigidly observed throughout. The vascularity of the tissue must be interfered with as little as possible. It is better to cut down upon and ligate the artery, in gangrene of the extremities, rather than to attempt the bloodless amputation by means of the Esmarch band, in consequence of the possible harm to the tissues, especially the blood-vessels, whose vitality is not the best."—*Annals of Surgery*, April, 1900.

Gustave A. Van Lennep, M.D.

RUPTURE OF THE LIVER AND GALL-BLADDER.—Vischer, Philadelphia, reports the following cases: C. A. J. received an injury, fifteen days before, to his abdomen; when seen he complained of pain in the abdomen, vomiting of bilious character, jaundice, clay-colored stools, urine bile laden; temperature 99° to 103°; abdomen greatly distended, and patient greatly emaciated. The abdomen was opened by an incision eight and one-half centimeters in length, parallel to and slightly above the crest of the ilium, when between two and three gallons of dark-greenish fluid of the consistency of bile were evacuated. Together with this, were numerous small pieces of bile-stained sloughs and blood clots. On introducing the hand through the incision, it was found that the fluid had occupied the entire left side of the peritoneal cavity, the intestines being adherent and displaced anteriorly and to the opposite side. A

second incision was made through the right linea semi-lunaris, exposing the lower margin of the liver, when another gush of similar fluid took place. Here, also, the bowels were found quite firmly adherent to one another. All of the tissues were bile stained.

At the site of the gall-bladder there was an apron-like fold of mucous membrane, which was recognized by the rugæ, and identified as the remnants of a mutilated gall-bladder by detecting an opening, through which a probe was passed, leading into the intestine. The wounds and cavities were packed and drained with iodoform gauze.

Reaction set in well, and the patient soon felt greatly improved, so that at the end of forty-eight hours an attempt was made to repair the gall-bladder. In this endeavor, it was found necessary to enlarge the wound in the right side by joining an incision, seven centimeters in length, at right angles to the upper portion of the original one. This gave free access to the entire hepatic region. The remaining portion of the gall-bladder wall was adherent to the convexity of the liver. This was partially dissected away, and the edges approximated by a continuous suture of fine silk, forming a trough, the free end of which was tacked to the peritoneal edges of the wound, to provide for drainage. To complete this trough, the deeper layers of the wound were united by three interrupted sutures of silkworm gut, which succeeded in converting the trough into a sinus, roofed by peritonæum. The remaining cavities were drained by gauze and tubes. At this sitting, it was found that the bile, also, drained upward over the convex surface of the liver, accumulating to the right of a suspensory ligament between the liver and the diaphragm. The patient made a gradual recovery; the flow of bile for the first few days being rather remarkable, inasmuch as at each dressing (and there were several daily), a large quantity, averaging from fifteen to twenty-five ounces, was withdrawn from the cavity between the liver and diaphragm. The drainage from the lower wound was less, but of the same character. The fluid, also, gradually underwent alteration; at the beginning it was pure bile, later it assumed a peculiar chocolate color, and had a consistency of "puree of pea," which, indeed, it was not unlike. It is interesting to note that this peculiar discharge continued to drain from both wounds up to the time of complete cicatrization, showing a free communication between the hepatic region and the left iliac fossa. The jaundice slowly disappeared, but the bowel movements were free from bile for several weeks, at the end of which time they gradually assumed a normal state. Eventually he regained his usual good health.

CASE II.—J. W., aged 26, was brought to the Hahnemann Hospital, having been struck in the right side by the falling of a heavy piece of machinery. On admission he was in a state of collapse, from which he slowly rallied. Examination showed a few slight abrasions on the lower portion of the right thorax, and a greater one on the anterior part of the left knee. In the course of a few hours the abdomen became gradually distended and painful, especially over the hepatic region. These signs were accompanied by extreme pallor, restlessness and drowsiness, together with a wiry pulse. Internal hæmorrhage from a probable rupture of the liver was suspected, and preparation for an immediate abdominal section was made.

Operation.—After the administration of a small quantity of ether, the abdomen was opened through the right semi-lunar line, the incision extending some seven and one-half centimeters downward from the lower border of the

tenth costal cartilage. On opening the peritoneal cavity, a large quantity of partly coagulated blood escaped. The hand being introduced, at once came in contact with a portion of the right lobe of the liver that had been torn through, the rent extending in a circular direction through the entire thickness of the organ, almost severing a portion which measured ten and a half by eight and three-tenths centimeters. This was attached by a small pedicle, as it were, some three centimeters in breadth. To this torn piece the gall-bladder was attached. The hæmorrhage, which was quite profuse, came from two large veins, which were readily secured and ligated; after which the parenchymatous bleeding was mostly controlled by a continuous suture of catgut, bringing the capsule of the superior and inferior surface of the organ together. The "pedicle" was ligated with silk, and the above sized piece removed with scissors, the gall-bladder having first been detached. The latter was now held up in apposition to the raw edge of the liver by a few interrupted silk sutures. Iodoform gauze was packed around the liver wound, and the incision in the abdominal wall partly sutured. The patient being almost depleted, saline infusion was practiced with gratifying result. He was returned to bed in far better condition than previous to operation. He progressed favorably until the evening of the third day, when he died suddenly, death being probably due to an embolism.

After reviewing the literature of liver injuries, he summarizes his conclusions as follows:

1. That injuries of the liver, followed by a greater or less hæmorrhage, are accompanied by shock, which is largely in proportion to the amount of the bleeding, and which has a tendency to grow progressively worse, terminating in collapse in a relatively short time.

2. Inasmuch as such injuries are usually fatal, operative interference, if at all undertaken, must be done at the earliest possible moment, for even after the hæmorrhage ceases, peritonitis is most prone to develop in these cases.

3. That in injuries to the gall-bladder, the shock is not so pronounced, and reaction usually sets in. The prognosis is, therefore, more favorable.

4. The escape of bile into the abdominal cavity, from a ruptured gall-bladder or ducts, is not necessarily fatal. Were it possible to recognize such an injury as a certainty, we would almost be justified in giving a favorable prognosis, and even in postponing operative interference until complete reaction from the shock has taken place.

5. That the mere drainage of the abdominal cavity after rupture of the gall-bladder will often suffice as an operative procedure. In late interference we are apt to find adhesions of the viscera to such an extent as to make anatomical landmarks and visceral relationships unrecognizable, and inasmuch as they prevent the dissemination of any septic matter that may be present, it is advisable not to disturb them.—*International Journal of Surgery*, May, 1900.

W. D. Carter, M.D.,

A CASE OF DOUBLE VAGINA AND DOUBLE UTERUS—FOUR PREGNANCIES.—Pearse, Kansas City, Mo., reports the following case, which is of interest on account of the rarity of such conditions, as well as from the fact that the woman who was the victim of the deformity not only remained in ignorance of its existence, but endured four successive pregnancies in comparative safety.

Mrs. K., aged 36 years, married, and the mother of four children. She stated that she had been married sixteen years, and had had four confinements. The first two children had been vigorous at birth; the third had been quite puny, but had reached childhood in safety. These three are to-day alive and well. During these three pregnancies she had suffered much pain and uneasiness in the lower abdomen and pelvis. In all three cases labor had been protracted, and recovery slow, but forceps had not been used. The fourth pregnancy gave her more pain than any of the preceding, and was marked at the middle of the ninth month by tearing pains and smart hæmorrhage. This continued at intervals for about six weeks, when (she says one full month beyond her normal period) tardy labor developed, and the fourth and last pregnancy terminated with a still-born child. It seemed to be of perfect development, and showed no sign of disease.

Examination showed a normal vulva, with a slight ridge extending back from the fourchette, and a corresponding one, so large as to resemble a prolapsed urethra, on the anterior wall. In the vagina were the remains of a complete septum, showing that two perfect vaginae had existed, and had been merged into one by the rupture of the septum. The cervix showed the remains of the double formation, but the right uterine cavity could only be traced about one or one and one-half inches, while the left was much deeper. The septum between them had been torn away for some distance, and the laceration had extended laterally across and involved the wall of the cervix on the right. On the left the laceration had extended deeply into the vaginal wall. A large, bleeding, granular surface, caused by these gaping lacerations, made it very difficult to examine them accurately, and, moreover, the patient's position and the light were also faulty.

It seems probable that the four pregnancies had taken place in the left uterus, and that inflammatory changes had so fixed the cervix in the last pregnancy that laceration at the ninth month had caused the pain and bleeding which then occurred, and possibly delayed the labor one month, as the patient averred had been the case.—*American Journal Surgery and Gynecology*, April, 1900.

W. D. Carter, M.D.

THE LATEST METHODS FOR THE TREATMENT OF UTERINE HÆMORRHAGE (Schaeffer).—Bi-manual massage is of first importance for postpartum hæmorrhage from atony of the uterus, and, next, strong traction on the cervix, drawing it down to the vulva with two Museux forceps, and if retention of parts of the ovum, tamponing the uterine cavity with some non-absorbent material, such as rubber. (This no doubt presupposes previous cleaning of the uterine cavity.) If there is postpartum hæmorrhage combined with a hæmorrhagic diathesis, tampon the uterine cavity with ferripyrin or gelatine gauze; in abortions up to the fifth month, use a large colpeurynter, smeared with gelatine, in the uterine cavity.

Hæmorrhage in consequence of hyperplastic endometritis, mucous polypii or incomplete abortion, requires curettement, followed by atmokausis (application of live steam to the uterine cavity). Ligation of the uterine arteries is rarely required. The hæmorrhage of fibroid tumors may be treated palliatively by the introduction of gauze treated with 5.10 per cent. gelatine, 1 per cent. formaline or ferripyrin. Hydrastis or stypticin can be given internally. Hæmorrhage from inoperable cancers can be treated best by atmokausis or

escharotic tampons with turpentine, formalin, chloride of zinc, pulverized charcoal, itrol, nosophen, and ferripyrrin. All irrigations in these cases should be ice cold.—*Deutsche Praxis*, No. 11-14, 1899.

George R. Southwick, M.D.

ATMOKAUSIS, OR THE APPLICATION OF LIVE STEAM TO THE UTERINE CAVITY (Steinbüchel).— Seventy-two cases form the basis of the report, a large percentage of which were uterine hæmorrhage from various causes. Curetting is advised as a preliminary operation, and should be combined with thorough dilatation of the cervix to avoid stenosis. The method often saves the patient from a more serious operation. It has been used with very good results for :

1. Dysmenorrhœa.
2. Endometritis with hæmorrhage.
3. Endometritis with profuse leucorrhœa.
4. Subacute and chronic gonorrhœa of the uterus.
5. Subinvolution of the uterus, both for hæmorrhages and to diminish the size of the organ.
6. Myomas when the uterine cavity is not long drawn out or asymmetrical.
7. Cancer, both for bleeding and suppuration.
8. Hæmorrhage after abortion, without any unfavorable effect on conception, pregnancy or labor.
9. Putrid abortion.
10. Septic endometritis.
11. To obliterate the uterine cavity, when a temperature of 110°-115° C. for over two minutes is necessary.
12. If obliteration is not desired, the use of the steam must be very short, 7-10 seconds.—*Monatschrift für Geburtshilfe und Gynäkologie*, February, 1900.

George R. Southwick, M.D.

INDICATIONS FOR THE INDUCTION OF PREMATURE LABOR, 100 CASES. (Bar.)—The operation can be performed with the bougie or colpeurynter. The mortality of the mothers is 1 per cent., of the infants 26 per cent. The proper period is determined by Perret's cephalometer. The lowest degree of pelvic contraction in which the operation is permissible is 7 cm. In a conjugate of 7-8 cm. the infant mortality is still 50 per cent. ; in 9-10 cm., 8 per cent. Eight cm. are necessary for good results, and these are better in multipara than in primipara.—*Transactions Obstetrical Society of Paris*, 1900.

George R. Southwick, M.D.

THE CASUISTICS OF THE INDUCTION OF PREMATURE LABOR AS ILLUSTRATED BY A CASE IN WHICH THE OPERATION WAS PERFORMED ON ONE WOMAN IN NINE SUCCESSIVE PREGNANCIES. (Grandin.)—Pinard, at the last International Congress for Obstetrics and Gynæcology, stated that in contracted pelvis both this operation and perforation of the living child should be abandoned. One-third of the children perish and the remainder are incompletely developed, and for the most part are invalids and candidates for disease. Pinard, after making this statement, advises the delivery of such cases by symphyseotomy or Cæsarean section. This opinion found scarcely any support at the Congress. Symphyseotomy showed a maternal mortality of 13 per cent. for the children and 12 per cent. for the mothers, and may be accompanied by the most serious complications. Cæsarean section shows a mortality of 10 per cent. for the mothers and 13 per cent. for the children.

The induction of premature labor has a much higher rate of mortality for the children, 33 per cent., but the mortality for the mothers is not much more than for physiological labor, as illustrated in the following case :

Mrs. S. ; æt. 45 ; had rachitis in childhood, and was married at 23. The first pregnancy went to full term, and a difficult labor was ended on the fourth day by craniotomy. The next pregnancy was terminated in the ninth month by the introduction of an elastic bougie. The child was born in good condition, but died afterward through the carelessness of the nurse in giving it a cold bath and leaving it uncovered for some time in a cold room. The third pregnancy was again terminated in the thirty-fourth week by a bougie. The infant was feeble, but grew strong and vigorous. The fourth pregnancy was terminated in like manner at the thirty-fourth week, but the child was transverse and extracted by version in an asphyxiated condition. The fifth pregnancy was terminated by the bougie at the thirty-sixth week, and a very healthy boy born. The sixth pregnancy ended in like manner with a healthy girl. The seventh pregnancy ended in like manner with induced labor at the thirty-six week, but with considerable trouble, as the bougie had to be introduced repeatedly for a week, and the child was still-born. The eighth pregnancy also slight reaction to the bougie and a colpeurynter was used ; a healthy boy was born. The ninth pregnancy was interrupted at the thirty-sixth week, and a feeble girl born, which died soon after. The tenth pregnancy terminated spontaneously and prematurely about the thirty-sixth week, with the birth of a healthy boy. The result of induction of premature labor in this patient was the birth of five healthy children, and one more would have lived had it not been for the carelessness of the midwife.—*Centrallblatt für Gynäkologie*, No. 17, 1900.

George R. Southwick, M.D.

HYSTERECTOMY FOR SEPTIC METRITIS AND PERITONITIS. (Grandin.)—The septic puerperal patient should be subjected to a most thorough physical examination, preferably under anæsthesia, for the differentiation between saprophytic and streptococcic infection.

Sapremia (saprophytic infection) yields to local operative measures, except where expectancy has ruled or streptococcic infection has been superadded. In such an event a major operation may be necessary, usually at a remote period from the initial infection. If the clinical symptoms are low, especially where the pulse is rapid in proportion to the temperature, a *warning of general systemic infection*, sapremia having been ruled out, though no focus of infection in the pelvis can be detected, and other sources of systemic disturbance being excluded, an exploratory abdominal section is indicated for an absolute diagnosis. Early removal of the uterus and appendages before there is general systemic infection is feasible.—*American Journal of Obstetrics*, April, 1900.

George R. Southwick, M.D.

THE CAUSES OF HÆMORRHAGE FROM UTERINE MYOMAS. (Clark.)—The writer carefully studied one hundred tumors. Injected preparations showed that the usual opinion that the blood-vessels passed from the sides of the uterus in finer and finer subdivisions up to the median line without anastomosing with each other was false. He found there was a network of freely anastomosing vessels from both the uterine and ovarian arteries. Any circulatory disturbance at one part affected the whole, and any compression on

one side led to venous stasis and arterial distention on the other. For the same reason the endometrium, offering the least resistance, becomes most readily the site of bleeding, either by diapedesis or actual rupture of a vessel. Subperitoneal myomas affect the circulation the least and do not increase menstruation and lead to atrophy of it and hæmorrhage. The latter is most marked with submucous fibroids.—*Johns Hopkins Hospital Bulletin*, Jan., Feb., March, 1899.

George R. Southwick, M.D.

THE AUTOINTOXICATIONS OF PREGNANCY (Bouffe de Saint-Blaise).—Paris, Ballière et fils, 1899. The author first considers thoroughly the physiology of autointoxication as well as the physiology of normal pregnancy; he next takes up the pathology of autointoxication outside of and also during pregnancy, and draws the following conclusions: Autointoxications exist in every healthy man, and produce no symptoms so long as the eliminating organs, the liver and the kidneys, are intact; they occur during pregnancy to a higher degree, and thus may be special poisons produced by pregnancy. It is important to observe that the normal glycogenic functions of the liver may be disturbed by previous disease of this organ, by chronic disease of the kidneys, by gastric affections, etc. Even a slight disturbance may produce a vicious circle which may be difficult to cure. The condition of the kidneys is of great importance, but less so than the liver; severe symptoms may occur with sound kidneys. The poisons retained in the blood are very numerous or act individually different, as seen in the changing symptoms (headache, pytalism, vomiting, eclampsia). The most exact observation of every pregnant woman is necessary, if there are signs of autointoxication. If the symptoms do not improve with proper therapeutics and diet, the induction of premature labor is indicated. Chloral is recommended for eclampsia, as it does not injure the liver. Chloroform anæsthesia is preferable for the same reason.

George R. Southwick, M.D.

COMPARISON OF PERMANENT RESULTS AFTER SYMPHYSEOTOMY AND CÆSARIAN SECTION (Abel).—The report is from the Leipsic Clinic, from patients delivered in 1887 to 1894. Symphyseotomy was performed twenty-five times, once repeated. Cæsarian section was performed thirty-four times, twice on fourteen women and three times on four women. In the former operation the patients were able to walk, on the average, in thirteen weeks. The restitutio ad integrum required a longer time in proportion to the disproportion between the contracted brim and size of the child. The method of uniting the symphysis had no effect on the final result nor the firmness of union. There was in all cases some mobility of the symphysis, which did not affect walking or ability to work. The patients treated by the open method were able to walk first.

The twenty-one cases of Cæsarian section with normal convalescence were able to do light work in six weeks. Zweifel now uses black floss silk for the uterine wound in preference to catgut, as the latter softens early and unties easily. There is danger, however, of fistula forming subsequently in consequence, and extensive adhesions between the uterus and abdominal wall.

Symphyseotomy made subsequent labors much more easy. Fourteen of these women have conceived, and in only one was the operation repeated, and sixteen children were born alive after short labors. In pregnancy after Cæsarian section severe complications were produced by the adhesions. The

final results of both operations are good. Those of symphyseotomy at first are not so good, but there are also disadvantages to Cæsarian section. —*Archiv für Gynäkologie*, Bd. lviii., H. 2.

George R. Southwick, M.D.

A CASE OF PANNUS TRACHOMATOSUS CURED BY AN INTERCURRENT ERYSIPELAS.—The patient was a girl who had been under treatment some time for trachoma, which was present in a marked degree in both upper and lower lids. The corneæ were covered with a thick pannus. The patient was decidedly strumous in appearance. She was put through the routine treatment, roller forceps, etc., and slight improvement resulted. Erysipelas developed without any apparent cause at the upper and right side of the nose. The inflammation spread over the face and skull, and attacked the lids so that they could not be opened. Fourteen days later, when the erysipelas had disappeared, and when it was possible to open the lids again, it was noticed that with the exception of one or two vessels the pannus had almost entirely disappeared, and that the dense corneal cloudiness had cleared in a marked degree. The author concluded that the toxins of erysipelas were present in the lymph channels, and it was these toxins which caused the rapid disappearance of the pannus. An analogous phenomenon is witnessed in application of the jequirity bean to gonorrhœal ophthalmia.—Dr. S. Baek (*Klinische Monatsbl. für Augenheilkp.*).

Wm. Spencer, M.D.

LARGIN—A NEW SILVER SALT.—Dr. Sydney Stevenson reports in the *British Medical Journal*, March 17, 1900, his experience with a new salt of silver—Largin—in certain diseases of the eye, in conditions similar to those in which silver nitrate is indicated. He states that largin causes no pain, even when in concentrated solution. While quite efficient in the destruction of most of the microbes which are found in the conjunctiva, including the Koch-Weeks bacillus, the microbicidal power of protargol and silver nitrate is greater in gonorrhœal ophthalmia. Merck claims that largin contains 11.1 per cent. of metallic silver.

Wm. Spencer, M.D.

PATHOLOGICAL AND ANATOMICAL CHANGES OF THE EYE IN CONGENITAL SYPHILIS OF SUCKLINGS.—Lokteff examined the eyes of twelve bodies of syphilitic children who had died at the age of seven days to ten months. Ten of them clearly showed signs of syphilis in the internal organs. The iris was pathologically changed in all the twelve cases, the choroid in eight, the ciliary body in three, the retina in two. The cornea was not once affected. The changes were in general the same as in the internal organs; endo- and perivascularitis, sometimes hyaline degeneration of the blood-vessels, as well as round-cell infiltration of the proper tissue of the coats of the eye.—*Thesis, St. Petersburg*.

Wm. Spencer, M.D.

PARESIS OF THE SUPERIOR OBLIQUE MUSCLE CAUSED BY GRIPPE.—The 27-year-old patient, well nourished and of good constitution, had suffered neither from syphilis nor rheumatism. In 1898 he had influenza; at the same time diplopia was noticed, which disappeared a week after the influenza had worn off. In February, 1899, the patient had another attack of influenza in connection with diplopia. On examination a paresis of superior oblique muscle was found, which, according to the author, must be caused by nuclear disease.—Vereshiaguin (*Military Medical Journal*).

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

TREATMENT OF CONSTIPATION IN CHILDREN.—Dr. Moeser in managing the constipation of children, if the child still nurse, would regulate the diet of the mother or nurse. She should receive no wine, beer nor coffee. He warns especially against the foolish habit of permitting nursing mothers or nurses to drink beer to increase the quantity of the milk. The alcohol is excreted by the breasts, in a measure, and a certain quantity is taken thus by the child. The frequent appearance of spasmodic affections in little nurselings may be attributed to this as one of the causes. On the contrary, "milk makes milk" for nothing increases the quantity of milk as much as milk-drinking. The solid food of the mother should be as free from irritants and spices as possible. Too much meat is also not advisable, but rather a well-selected vegetable diet. A good quantity of fruit for the mother is useful in combatting the constipation of the nurseling. In the winter this is best given in the form of purées. Well-cooked apricots are especially useful in this as a corrective. Naturally, the whole life of the mother should be hygienically arranged: careful care of the skin with lukewarm or cool baths, plenty of exercise in the open air. If a child be bottle-fed, if it does not have at least two movements of the bowels daily, its whole diet should be changed. Instead of cow's milk it is better to feed goat's milk; thick porridges are to be avoided. Sufficient water should be given, and every one-half to one hour, if it does not sleep, it should receive a teaspoonful of fresh, unboiled water. It is remarkable how many mothers have a fear of giving their children cold water, though it is comparatively free from bacteria. Boiled water tastes as disgusting to little children as to adults. At the same time one may give a nurseling, without harm and with good results, the juice of fresh fruits, as lemons, oranges, apples, grapes, currants, etc. The juice of prunes, a teaspoonful two to three times a day, acts as a laxative.

Massage of the abdomen if properly administered, and moist applications also may be employed. Rectal injections of a weak solution of salt and water, or with several teaspoonsful of oil added, are wholly harmless, if carefully used.

As to remedies, it is well to begin with *sulphur*, which may be alternated with *nux vom.* *Calcarea acetica* is indicated when the children are pale, fat, and inclined to rachitis and scrofulosis. *Lycopodium* when the child's abdomen is distended by gas, and it is distressed by frequent passages of flatus. This latter remedy may be followed by *graphites*, if it does not act. *Natrum mur.*, *sepia*, *alumina* and *plumbum* may also be indicated.

Of the vegetable remedies there are, besides *bryonia*, *belladonna*, *podophyllum* and *china*. *Opium* is indicated rather in acute constipation with great congestion of the head than in the habitual form of this disease. The selec-

tion of the indicated homœopathic remedy is not difficult if one take note of the whole appearance of the child, its constitution, and any diseases or unhygienic habits of its parents. With the aid of these rules and remedies not only may one feel sure of relieving temporarily, but also of curing permanently, a case of chronic constipation.—*Homœopathische Monatsblätter*, No. 3, 1900.

THERAPEUTIC NOTES.—In albuminuria Dr. Olivé speaks highly of *gallic acid* if there be chloro-anæmia; *capsic.* in grave acute albuminuria with hæmaturia; *terebinthina* if the urine is bloody, with pus and casts; *cantharis* if the symptoms of congestion predominate, and if there be no alteration of the structure of the kidneys.

Dr. R. Day, of London, asserts that he has cured three cases of acute anterior poliomyelitis with *secale corn.* 2x and faradization.

Dr. Neatby, in a lady with nervous palpitation of the heart, a sensation of a ball in the throat, attacks of dyspnœa, anæsthesia of the right side, headache, pains and weakness in the back, brought about a complete cure with *naja* 6x and 30x.—*Journal Belge d'Homœopathie*, No. 1, vol. vii., 1900.

Frank H. Pritchard, M.D.

TREATMENT OF AORTITIS.—Dr. P. Jousset used the three following remedies in the treatment of aortitis:

Arsenite of Antimony.—I have often administered this remedy in the treatment of aortitis (chronic). Giving from five to ten cgms. daily, he continues it for weeks. Though he has often obtained an amelioration he has never cured with this drug.

Plumbum.—This drug is that which, according to the law of similars, is most closely indicated in aortitis, for in chronic poisoning by this drug both aortitis and arterio-sclerosis have been observed to be produced. Unfortunately clinical experience does not confirm this, and until now it has failed both in aortitis as well as in arterio-sclerosis and interstitial nephritis. Is it a question of dose? (Goodno thinks that it may be due to the human race being more or less indifferent to the action of lead on account of its manifold uses in articles used by us. He recommends the iodide of lead instead as worthy of a trial.)

Aurum, phos., lachesis and *cuprum* are indicated by some of their symptoms, yet he cannot bring any clinical evidence in their favor.

Glonoine.—This drug corresponds to the dyspnœa, and nearly always relieves the patient. The dose is a drop of the first decimal dilution in a spoonful of water, a dose every half-hour until no more than ten doses are taken.

The complicating conditions and symptoms require their corresponding treatment.—*Ibidem.*

TREATMENT OF ALCOHOLISM.—In the Belgian journal, *Journal Belge d'Homœopathie*, vol. viii., No. 1, the following treatment of alcoholism is recommended:

Antimonium Crudum.—Sadness. The tongue coated thick and white. Vomiting, especially after eating and drinking. Vomits food, bile, or mucus. No thirst.

Arsenic. Album.—Great anxiety, agitation, weakness. Thirst, with desire to drink but slight quantities at a time. Burning in the stomach. Nausea with weakness and trembling. Heat and chilliness. Violent vomiting of food, liquids, which are bitter, greenish or yellow, or even black or bloody. Vomiting immediately after having eaten.

Bryonia Alba.—Very irritable, easily frightened, vexed or violent. Mouth and throat dry, with thirst for great quantities of water. The tongue is coated with white in the centre, but with the edges clean. A bitter taste, with nausea and vomiting, aggravated by the least movement. He feels better if he keeps wholly quiet.

Nux Vomica.—Irritable, quarrelsome, mischievous. Very sensitive to external impressions. The tongue very thickly coated white or yellow. There is a bitter, sour, or putrid taste in the mouth. Continual nausea. He feels that if he could vomit he would feel better. Other remedies to be thought of are: ipecac., phos., cham., and coffea.

Frank H. Pritchard, M.D.

VESICARIA COMMUNIS IN ALBUMINURIA.—Dr. Cowperthwaite asserts that in an experience of six years he has not failed once with this drug in causing the albumin to disappear from the urine, even in cases of actual Bright's disease. It is necessary to use only the imported tincture, fifteen drops every four hours.—*Ibidem*.

CALOMEL IN HYPERTROPHIC BILIARY CIRRHOSIS.—Dr. P. Jousset has great confidence in the action of mercurius dulcis in the treatment of hypertrophic biliary cirrhosis. He administers the first dec. trituration.—*Ibidem*.

Frank H. Pritchard, M.D.

LYCOPodium IN DISEASES OF THE LIVER.—Spaulding, of Los Angeles, Cal., states that in diseases of the liver lycopodium is to be thought of when the hepatic region is sensitive to contact, with a full tensive feeling as if the liver were swollen. These are "key-notes" of the remedy. There is some times, though not especially marked, a feeling as though a cord were tied around the waist. These are the symptoms which suggest lycopodium in chronic hepatitis; and with the Hippocratic grayish face the remedy is clearly indicated.—*Pac. Coast Journ. of Hom.*, April, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF A WEAK HEART.—Nicholson, in a paper read before the Western Counties Therapeutical Society in London, defines a weak heart as one showing a feeble radial pulse and weak apex beat, without any well-defined morbid condition and marked by no definite subjective symptoms. His treatment includes dieting according to Balfour's well-known rules, judicious exercise, and drugs. After a *résumé* of six cases successfully treated, he states that the drug that he has found most successful is strychnine, and it is often sufficient to effect a cure alone. The reason for this, he thinks, is that strychnine is such a general stimulant of muscle, nerve and circulation, and in small doses he has never perceived any reaction. He usually gives $\frac{1}{10}$ to $\frac{1}{20}$ gr. during the day. Digitalis is necessary when the pulse is quick or irregular, and he gives more frequently the granules of crystallized digitalin in 1 milligram doses. In dilatation he finds the θ tincture effectual in three- to four-drop doses.

Strophanthus has a very similar action to digitalis, and though he has frequently used it he finds it in no way superior. When digitalis is indicated strychnine is usually indicated at the same time, and practice proves them to work well together. Arsenic and iron are especially useful in anæmic and chronic cases. He does not profess to unravel the action of these medicines. Tonics which are direct stimulants of function do not exert their therapeutic

power in very small doses, and perhaps they should not be included under the rule of "similia;" but as physicians we cannot do without their aid, explain it as we may. We certainly use the primary action of the remedy, and hence need a more material quantity, but he thinks the result is as rapid in prescribing a "dynamized" drug from purely symptomatic indications.—*Am. Hom.*, April 16, 1900.

F. Mortimer Lawrence, M.D.

COAL-TAR PRODUCTS AND THE SPECIFIC INFECTIONS.—The action of the coal-tar products in specific infectious fevers is to prevent compound elimination of the toxins formed within the system. This condition lasts as long as the drug is taken, and when it is withdrawn the urine and fæces become hyper-toxic, showing that the organs of elimination are again active. The interference with elimination caused by such antipyretics as acetanilid, antipyrin, etc., should condemn their use, even when the accompanying pain is severe.—*Med. Era*, April 15, 1900.

F. Mortimer Lawrence, M.D.

ARSENIC AND CARBO VEG. IN HÆMORRHAGE.—According to Buck, of Kingman, Kansas, the primary action of arsenicum is to kill tissue-cells, and by breaking them down a low, passive hæmorrhage is produced, and it would be madness to give arsenicum in physiological doses for hæmorrhage. However, in a low, passive hæmorrhage that is caused by broken-down tissue, like typhoid fever, arsenicum in highly-diluted form would be indicated. Right here comes in a very similar remedy—carbo veg.—which devitalizes the blood and exhausts the nervous system in its physiological effect on the system. This is indicated in hæmorrhages from the lungs, not only in hæmoptysis, but also in bronchorrhagia, as well as hæmorrhages from the bowels. The eclectics use it a good deal for menorrhagia and metrorrhagia. To distinguish carbo veg. from arsenicum patients the former, while anxious, do not have the restlessness. Both have the violent burning, but in the arsenicum patient there is the irritability of fiber and mind while there is a torpidity in carbo veg. There is a coldness—cold, clammy sweat and collapse.—*Med. Arena*, June, 1900.

F. Mortimer Lawrence, M.D.

REMEDIES IN RENAL HÆMATURIA.—Buck states that were he to have a case of hæmaturia where the blood is thoroughly mixed with the urine, indicating that the bleeding comes from the kidneys, he would prescribe turpentine, and in accordance with his own experience would cure the case. Heaviness and pressure in the region of the kidneys, violent burning and drawing pains in the same region, would be additional symptoms that would be a help to confirm his choice. In cantharis, while it may be indicated when the kidneys are the source from which the blood comes, yet if the blood is rather bright red and in streaks through the urine, he would think it came from the bladder or urethra. There would be intolerable tenesmus of the bladder; violent cutting, burning pains in the neck of the bladder, extending to navicular fossa of the urethra; violent burning, cutting pains in the urethra before, during and after urinating; urine scalds, passing drop by drop.—*Med. Arena*, June, 1900.

F. Mortimer Lawrence, M.D.

INDICATIONS FOR TREATMENT IN CHRONIC NEPHRITIS.—Dr. Giles Goldborough, of London, recalls the fact that Dr. Rose Bradford, in his recent interesting lectures on the subject of the pathology of the kidneys, pointed out that only a very small portion of the kidney is really necessary for the maintenance of a fairly adequate renal function if this portion is healthy. In view of this fact, in cases of disease the greatest importance is to be attached to an early diagnosis, and an estimation continuously and repeatedly as to how the renal function is being carried on. This estimation is based upon an inclusion of all the clinical data available. In a clinical case reported by Dr. Goldborough the quantity of urine passed, the specific gravity and the amount of albumin from day to day are carefully tabulated. Much improvement followed the exhibition of arsenic, and its effects suggest these queries: Could the arsenic be responsible for the asthma which developed in this case? Would a higher dilution of the drug have answered the same purpose? The writer adds that he has come to regard the liq. arsenicalis B. P. as a more reliable preparation than our 1c and 3x preparations.

In conclusion, Dr. Goldborough invites our attention to the value of apis and picric acid in chronic nephritis. He suggests that apis may be specially indicated in the transition from acute to chronic nephritis, and when there is much œdema present. Picric acid he believes to be useful when the characteristic blood state produced by the drug contributes its quota of symptoms to the case.—*Journ. of the Brit. Hom. Society*, April, 1900.

F. Mortimer Lawrence, M.D.

BRYONIA IN ACUTE NEPHRITIS, WITH DROPSY.—Patton, of Montreal, states that his cases have largely presented bryonia symptoms. The modality of discomfort on motion and the varied indications of dry mucous and serous membranes have been the most universally marked symptoms presenting. A generalization of this kind, if kept prominent, is more easily recalled by the practitioner than any set row of symptoms. At times his patient has presented the restless, anxious aspect of arsenic. The pearl-white skin, the thirst and anasarca have emphasized the gastric uneasiness. In these cases the drug has worked benefit. But because of its affinity for serous membranes, he has found bryonia most useful.—*Med. Century*, May 1, 1900.

THE TREATMENT OF GANGRENOUS ANGINA.—In this condition Patton, of Montreal, advises the following:

1. Spray every hour with peroxide, 1 to 4 of water.
2. Immediately after, spray with a solution of black hamamelis, 1 to 10.
3. Before any nourishment, spray with peroxide, and gargle with warm salt water.
4. Use four times daily some demulcent food, such as marshmallow cream.
5. Burn cresolin or formalin lamp as disinfectant of exhalations.
6. Remedies, in order of merit: Kali bich., mercurius cyanide, mercurius biniodide, hepar, mercurius nitr., lachesis and phytolacca.—*Med. Century*, May 1, 1900.

F. Mortimer Lawrence, M.D.

THE REMEDIES FOR CHRONIC DIFFUSE NEPHRITIS.—According to Blackley, of London, in the treatment of chronic diffuse nephritis the drugs to be depended upon are few in number (except where intercurrent acute attacks or complications occur); they are mercurius corrosivus and arsenic. The effects of the former upon kidneys and urine are as follows:

In *acute* mercurial poisoning the kidneys are increased in volume, and the parenchyma much injected, and on microscopic examination of the secreting epithelium degenerative changes are found to have begun already. In experimental poisonings by perchloride of mercury, Klemperer found that after a period of from five to ten hours the kidneys already presented a pronounced hyperæmia; by this time there were small hæmorrhages into the parenchyma, and the secreting epithelium had become turbid. The urine was smoky or bloody, rich in albumin, and deposited granular and fatty casts. In *subacute* poisonings the urine is albuminous, and contains hyaline or epithelial casts, sometimes mixed with blood, and in grave cases there is complete anuria. The urine is often slightly fluorescent and occasionally red, owing to a remarkable augmentation of urobilin. Examined post-mortem, the kidneys are found in a state of acute parenchymatous inflammation, and there is a necrotic condition of the cells lining the contorted tubules.

An interesting case of poisoning by seven grammes of sulphate of mercury is narrated by Von Jakseh as occurring in Nothnagel's clinic in Vienna (*Die Vergiftungen*, p. 223). The urine passed was slightly turbid, of a specific gravity of 1011, hæmoglobin was shown by Heller's test, and albumin by all ordinary tests. The sediment on standing was found to contain :

1. Pavement epithelium of various forms.
2. Granular casts covered with leucocytes.
3. Large leucocytes of the most diverse forms, some granular with large eccentric refracting nuclei, and smaller ones with nuclei less apparent.
4. A few red corpuscles.
5. Concretions of uric acid.
6. Fat droplets.

At the necropsy the kidneys were found in a condition of parenchymatous nephritis, being pale, especially in the cortical part, and exuding a turbid juice—a very fair picture of large white kidney.

In acute arsenical poisoning the urinary conditions are scantiness or suppression of urine, presence of albumin, and (in cases of poisoning by inhaling sublimed arsenic) hæmaturia (Tachenius). In slow experimental poisoning of cats by arsenite of potash, Quaglio succeeded in producing a genuine Bright's. The urine voided during life was scanty, though the solid constituents were found below normal, neutral in reaction, albuminous, and deposited blood globules, fibrinous casts, renal epithelium and fat. Death was always preceded by coma. Post-mortem, the kidneys were found large and hyperæmic, and the epithelium was fatty and granular. Add to these the cardiac, digestive and urinary symptoms of arsenic and the morbid appearances recorded in some of the cases of poisoning, and we have a very close picture of the later stages of large white kidney, of its atropic form, and even of the symptoms present in granular contracting kidney.

For intercurrent attacks of acute nephritis, cantharis and apis are indicated. For dropsy free diaphoresis must be obtained, the measures including packs, hot-air baths, vapor baths, or hypodermics of pilocarpin, while purging is not to be despised. To stimulate the flow of urine apocynum, apis or diuretin may be tried; heart tonics have a benign effect, and puncture of the skin is a late resort. For the dyspnœa glonoin and other nitrites may be exhibited.—*Jour. of the Brit. Hom. Society*, April, 1900.

F. Mortimer Lawrence, M.D.

THE HAHNEMANNIAN MONTHLY.

AUGUST, 1900.

THE BOTTINI OPERATION FOR HYPERTROPHY OF THE PROSTATE: A MODIFICATION OF ITS TECHNIQUE.

BY LEON T. ASHCRAFT, A.M., M.D., PHILADELPHIA.

(Read before the Surgical and Gynæcological Association of the American Institute of
Homœopathy, Washington, D. C., June 18, 1900).

Mr. President and Members of the Society: At the present time Bottini's operation for hypertrophy of the prostate occupies the first place in the list of radical operative measures that have thus far been employed for the cure of that condition. Such a positive statement necessarily demands something apart from an individual expression. Results must be shown, personal experiences must be cited, and all the data obtainable must be referred to, in order to keep this operation in its deservedly proper place.

In 1872 Bottini first practiced prostatotomy, by electricity. Guiteras* is responsible for the statement that his results were good. About two years ago Freudenberg, of Berlin, revived the operation, and since then, in addition to some of the surgeons of Europe, it has been practiced in this country by Meyer, Guiteras, Downes, Horwitz, Morton (of Brooklyn), Carelton, Van Lennep, and others whose names I cannot recall, and I presume also by many members of this Association. Unfortunately, it is within my power to quote only the results obtained by the following operators:

* *N. Y. Med Journal*, April 29, 1899.

	Cases.	Deaths.
Meyer,	48	1
Guiteras,	12	0
Morton,	5	0
Downes,	9	1

a mortality of 2.7 per cent.

Lydston*, in a series of 164 cases, reports a mortality of 4.8 per cent. Compare this with the mortality associated with other radical operations employed for the relief of this condition. Except vasectomy, a method rather unsatisfactory in its results, the others range, from castration, seven per cent. (White), eighteen per cent. (Cabot), perineal prostatotomy, six per cent., and supra-pubic and perineal prostatectomy, seventeen per cent. This operation fulfils all the requirements of a cure, since it reduces the urethro-vesical level by removing the impediment to the passage of urine, thus causing a perceptible diminution in the frequency of urination, and measurably acting as an important factor in the cure of the usually existing cystitis. Most operators, however, agree that a cystitis, if present, is rather slow in disappearing, and that, following operation, both local and internal treatment must be given in order to cure this complication. This led me to suggest my modification, of which I will speak later. Do any of the other operations performed for the relief of this condition fulfil *these* requirements? Castration, vasectomy or angio-neurectomy certainly does not. Prostatotomy does not. Supra-pubic and perineal prostatectomy may, if proper drainage and after-treatment be instituted.

Hard, fibrous glands, with enlargement of the middle lobe, are, because of their non-compressibility, better suited for successful, perfect work, although I obtained a very good result following operation upon a prostate of the so-called grandular type. The operation should be done as soon as the classical symptoms of this condition are recognized and confirmed, provided the patient objects to the personal use of the catheter. It should be at once resorted to upon the slightest break-down of catheter life. Pyelitis has been considered a contra-indication; yet in two of my cases this condition existed.

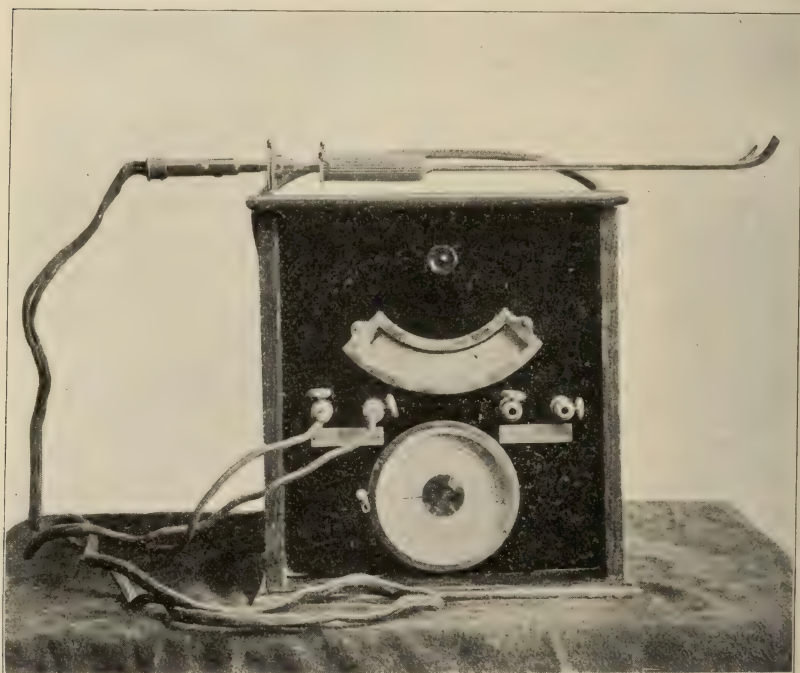
It is only necessary to give but a brief description of the in-

* "Text-book on Genito-Urinary, Venereal and Sexual Diseases."

strument, together with the principal points connected with this operation, and to present my reasons for it. Guiteras* has described the original procedure in its minutest detail. The necessary instruments are a galvano-cautery battery (one manufactured by the Kny-Scheerer Co.). It has a millampere-metre, which indicates the degree of heat; a Bottini incisor, which will sear a distance of eight centimetres. This is an instrument sixteen and a half inches long, and consists of a shank, shaped like a sound, eleven inches long; a rounded cylindrical handle on the proximal end, three inches long; and beyond this a straight pivot for the attachment of the electrical cable contact; a wheel, working the archimedian screw in the handle of the instrument, which draws back the cauterizing blade and the centimetre scale on its proximal side. From the tip of the instrument up into the handle of the upper surface is a slot, through which the male cautery blade passes. The instrument is made up of two distinct pieces, one fitting into the other. The outside piece is the female blade; it is a sleeve with a slot running through it. The handle has around it on the inside a thread, into which the screw-thread of the male part fits. The remainder of this female part is hollow, so that water may run through it, and there are two nozzles, extending down obliquely from the handle on either side, which serve as water-pipes, to which the tubing is attached, one leading up to the reservoir, suspended at a height of nine feet; the other leading down to a basin on the floor. The inside piece is the male blade, which can be entirely withdrawn from the female shaft. The screw that slides the male blade backward and forward in the female slot is entirely hidden from sight in the handle, and is the centimetre scale when the instrument is closed. The cable contact is a cylinder into which the electrical cable is inserted, the other end of which fits over the pivot of the instrument; two irrigating jars, one for the ice water, the other for a saturated solution of boracic acid; two pieces of tubing, one leading from the irrigating jar containing the ice water, the other from the instrument to the basin on the floor; a hand-syringe, of an eight-ounce capacity, two Mercier and two soft-rubber catheters, a perineal drainage tube, a Syme staff, hæmostats, and a scalpel.

* "Technique of the Bottini Operation," *N. Y. Med. Journal*, April 29, 1899.

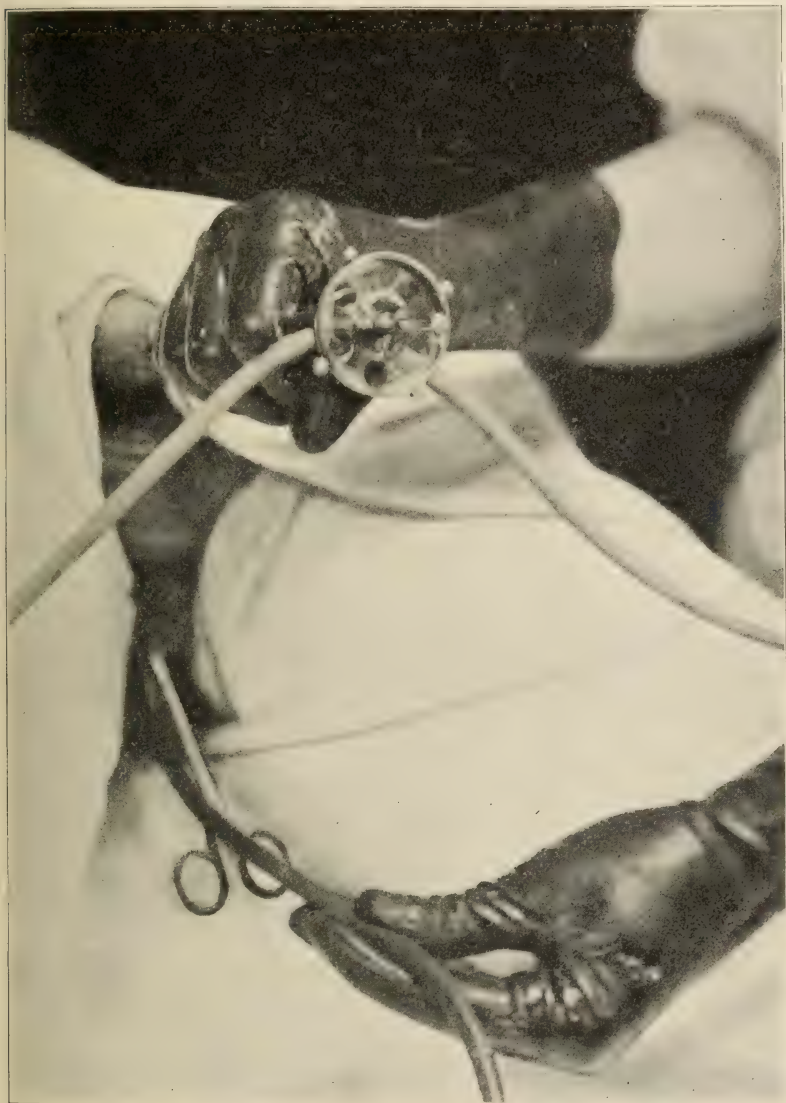
Profuse hæmorrhage immediately following, due to perforation of the urethra, has not infrequently been observed, demanding supra-pubic or perineal section for its control. Meyer * cites a case followed by absolute retention, demanding supra-pubic aspiration for three days consecutively. One of my cases developed urethral fever, due doubtless to prolonged instrumental interference within a chronically inflamed viscus, and the neglect to provide for sufficient drainage.



Again, the operation has been called a dark one. This, however, is hardly a serious objection to those skilled in bladder and urethral manipulation. Besides, thorough cystoscopic examinations undoubtedly serve as an intelligent guide to the amount of glandular overgrowth which should be seared. Accordingly, it occurred to me to combine this operation with a perineal urethrotomy, since by doing such a combination operation many of the complications known to follow an original Bottini would be entirely removed. First, because it slightly eliminates the factor of operating in the dark, by per-

* *Med. Rec.*, April 28, 1900.

mitting intra-vesical manipulation. Second, in the event of hæmorrhage, an avenue is at once afforded for tamponage. Third, that by tying in a drainage tube absolute retention is



entirely eliminated. Fourth, by forcibly stretching the prostatic urethra and neck of the bladder during perineal urethrotomy, cysto-spastic contraction will not occur. Fifth, with the drainage-tube tied in the bladder, that organ can be drained

and irrigated for several weeks, or indeed permanent drainage can be obtained, thus affording the best means for the cure of a cystitis. Some surgeons prefer to do a supra-pubic operation, in order to obtain vesical drainage, yet the perineal method is superior, because, first, it affords drainage by gravity: second, it is a most convenient artificial route for bladder irrigation: third, it lacks the dangers arising from septic inflammation of the præ-vesical space, a condition so frequently resulting from epieystotomy: fourth, its mortality rate is 12 per cent. less than the *high operation*—all very strong arguments.

Having then outlined my reasons for a combination operation, which I first practised in April, 1899, it might be well to describe its technic.

For several days before operating, the patient should receive five grains of urotropin after each meal: the bladder should be daily irrigated with a saturated solution of boracic acid. Before being brought to the operating-room, the customary preparatory treatment for perineal urethrotomy should be given, after which the patient should be thoroughly anæsthetized and placed upon the operating table in the proper position for the performance of external urethrotomy. It is desirable to see that the urethra has a calibre of 24 F.; a Syme staff is then introduced into the bladder and that organ entered by cutting down upon the membranous urethra, after which the staff is removed. A perineal drainage tube is passed into the bladder, which is irrigated with a saturated solution of boracic acid, after which the tube is removed. Then the prostatic urethra and vesical neck are stretched and any bleeding points secured. After this the patient is placed in the supine position and a pillow put under his hips. The bladder should contain about two ounces of a saturated solution of boracic acid. The irrigator should hang to the left of the patient, with its outlet tube connected with the incisor. The battery placed on a chair at the foot of the operating table, and the instrument then passed per urethra into the bladder. It is well to mention that while the female blade can be sterilized in the usual manner, the male blade must be thoroughly cleansed with soap and water, and then dipped into a solution of carbolic acid, 1 to 40, since, if the male blade is subjected to an extreme degree of heat, its insulation will become destroyed, as one terminal of the platinum

point is entirely insulated back to the rear end of the shaft. Heat will not destroy insulation while operating, as the female blade is maintained at a proper temperature by the cooling apparatus. Connect the battery and incisor by means of the cable, then rotate the beak of the incisor and pull it forward until it hooks behind the prostate. Insert the left forefinger into the rectum and feel the beak of the instrument; then remove the finger and grasp the handle of the incisor with the left hand. See that the ice water is running through the cooling apparatus and that the contact-screw is properly tightened. Then turn on the current to 40 or 45 amperes or to any number needed to overcome the obstruction. This can only be judged while operating. A white heat is undesirable, since it adds materially to the dangers of hæmorrhage. The wheel of the incisor is turned until the knife has traversed the required distance.

In this connection it is necessary to dwell upon several points: First, how many incisions shall be made, and how long shall each one be? The number, of course, would depend upon the location and character of the overgrowth. I usually sear the middle and both lateral lobes. Before incising it is necessary to find out how long each incision should be. This can be done approximately in the fibrous variety by passing a catheter into the bladder and measuring in centimetres the distance traversed before urine is withdrawn. A normal urethra should measure about 21 centimetres. In a few cases I have found urethræ 28 centimetres long. Here, in order to produce a urethral level to the fundus of the bladder, it will be necessary to make an incision six centimetres long in the middle lobe. Consequently it is important to have an instrument which permits of a cutting surface of seven or even eight centimetres. Attempts to ascertain the exact size of the overgrowth by rectal palpation, both before and at the time of operation, have been moderately unsatisfactory in the fibrous variety, and entirely so in the soft type. So that, in incising, it is better to depend upon the information which has been afforded by urethral examination. Each lateral incision should be about two centimetres long. This rule, however, is rather arbitrary, but as we have as yet no means for ascertaining the amount of lateral hypertrophy, we must rely upon cystoscopic

examination, upon our sense of rectal touch and upon our experience achieved in operating previous cases.

In soft cases, where there is a predominance of glandular elements, it will be very difficult to approximate, in centimetres, the distance that should be incised. It is advisable to sear each lobe two centimetres, and if the operation does not fulfil all of the requirements of a cure, it may be repeated. It is very unsatisfactory to operate upon this type. Before cutting, introduce the left forefinger into the rectum and feel for the tip of the instrument, then remove the left forefinger and grasp the wheel of the incisor with the left hand. When searing, always be careful to make traction upon the instrument with the right hand, holding it in close contact with the prostate; otherwise it will sink into the bladder. Each incision should be made slowly forward and then the distance traversed backward. Then the instrument should be slightly turned to the right and the right lobe incised, and the left lobe similarly treated afterwards. Disconnect the current, insert a drainage tube into the bladder through the perineal opening, and place the patient in bed.

The question may be asked: How does this procedure benefit. It may be answered by saying that furrows are burned through the obstruction, the eschars being removed during urination. Subsequently these gaping furrows contract, and a lower urethral level is obtained, thus allowing the bladder to empty itself. Searing also cuts off the blood supply to the prostate. The tube may be allowed to remain in place, unless funiculitis, epididymitis or vesical spasm occurs, in which event it may be removed. Perineal drainage is only indicated where cystitis exists, otherwise Bottini's unmodified operation may be practiced, omitting perineal urethrotomy. Ether is desirable for these reasons: It renders the operation painless; the possibility of spasmodic contraction at the neck of the bladder is eliminated; the patient maintains a fixed position in relation to the incisor, and will not pull away, thus minimizing the risk of searing too much and also burning in the wrong direction. Patients must remain in bed for two weeks.

I will not give a detailed report of my cases, but simply content myself with saying that, since attempting this combination operation, good results have invariably followed.

ILEO-COLITIS.

BY J. NICHOLAS MITCHELL, M.D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, Washington, D. C., June 20, 1900.)

A LARGER number of deaths occur each summer and autumn among children from intestinal diseases than from any other cause. The study of these diseases, therefore, is of unceasing interest and importance.

The particular form of disease I have chosen for attention at this time are those various lesions which we characterize under the name of ileo-colitis.

These lesions vary both in their locations and in their intensity, so that there may be simply a catarrhal inflammation, a catarrhal ulceration, a follicular ulceration, or a membranous inflammation, and the symptoms and their severity depend upon the character and the location; and furthermore, while they are far more serious than the lesions of the superficial epithelium, such as are found in the acute gastro-intestinal infections, yet it is important to keep in mind that they are often the conditions in which these latter terminate.

Ætiology.—Very little is known definitely as to the nature of the infection in cases of ileo-colitis. Amœba have been found in the stools, and streptococci have been found associated with the deeper lesions of the intestines, but thus far no positive deductions can be made as to whether they cause or are the result of the morbid condition. There is much doubt also as to the infectious character of ileo-colitis; and no epidemics in the true sense have ever been noted.

About all that can be positively stated is that it is a disease of infancy and childhood; that it occurs most frequently in the summer and early autumn; that it is a sequel to gastro-intestinal disease, and to any of the infectious diseases, particularly measles, diphtheria and broncho-pneumonia.

Lesions.—Under ileo-colitis, as a name, are included all the more grave lesions of the intestines, but it is sufficient for my purpose to call attention to the classification made by Holt, in

which he states the frequency with which the different varieties of the ileo-colitis were found in eighty-two autopsies.

Follicular ulceration,	.	.	.	.	.	.	.	36
Catarrhal inflammation,	.	.	.	.	.	.	.	26
Catarrhal ulceration,	.	.	.	.	.	.	.	6
Membraneous inflammation,	.	.	.	.	.	.	.	14
								<hr/> 82

Associated with ileo-colitis is found broncho-pneumonia very frequently, and, in fact, in quite a large number of the cases which die this is the cause of death.

Bronchitis is also very common. Acute degeneration of the epithelium of the kidney is frequent. No characteristic changes are found in the liver, heart, brain or spleen.

Symptoms.—The symptoms differ according to the character of the lesion, and at times it is impossible to differentiate except in the most general way between the catarrhal, ulcerative and membraneous forms.

The onset of the disease is generally sudden, often vomiting being the initial symptom. In many cases the symptoms for the first day appear like those of severe indigestion, *i.e.*, vomiting, pain, fever, and frequent thin, green or yellow stools containing undigested matter, with later appearance of the characteristic stools of mucus and blood, though I have seen cases where the blood, mucus and tenesmus were the first symptoms which showed themselves.

The stools are very characteristic. They are small in quantity, not exceeding a tablespoonful at times, and very frequent, occurring in some cases every half hour, and preceded by much straining and tenesmus. At first they are composed of blood and mucus mixed with faecal matter. The blood is not discharged in clots, but generally is streaked through the mucus and faecal matter. Thin blood is sometimes present, and, in fact, in one of the worst cases I ever saw the infant of sixteen months old passed from the very beginning of the disease nothing but blood for the first twenty-four hours. Later on in the disease, blood seems to be less in quantity, while the mucus predominates, many of the stools consisting of it alone, while others are composed of mixed mucus and faecal matter. The color of the stool now becomes a dark-brown or a brownish-

green, and at times has a heavy, sickening odor. With every stool there is, with the great straining, a prolapsus ani. From the outset a characteristic condition is fever. The temperature is usually high, varying from 102° to 104° for the first day, and later, ranging from 99° to 102° , though some mild cases never have a higher temperature than 101° .

The appetite is lost for the first few days. Abdominal pain is present, with increase in intensity before each stool; there is usually tenderness along the colon. Prostration is not marked, and, in fact, it is remarkable how strong the babe often seems with such severe and painful symptoms. Though the appetite is very poor, if not entirely lost, the thirst is intense.

The difference between the mild cases and the intenser catarrhal cases with ulceration, is in the higher grade and greater persistence of the fever, and in the more frequent stools; the greater quantity of blood; more marked prostration; a dry tongue, with sordes on the lips; more marked nervous symptoms.

In severe cases death occurs sometimes in a few days, from prostration and from sepsis, or if recovery is brought about, the convalescence is very tedious, with frequent tendencies to relapse. Even in the mildest cases the convalescent step is slow.

The first symptom of improvement in the disease is the disappearance of blood from the stools, which also become less frequent, with gradual diminution in the quantity of mucus, until they take on more and more the characteristics of an ordinary diarrhœa, *i.e.*, thin yellowish, brown, or green color. As a rule, one may judge that if fever, even though slight, continues for several weeks, with brown mucus stools, and the infant loses flesh markedly, that ulceration has occurred.

Occasionally we encounter cases which have had apparently but a slight attack, with no high range of fever, but where there is a marked tendency to relapses in the frequency of the stools and in the quantity of the blood and mucus. If, in such a case, during one of the exacerbations, there should be a sudden return of the above symptoms, together with vomiting and persistent discharge of large quantities of mucus, and but little fæcal matter, with continued fever, not high neces-

sarily, but persistent in character, we may presume that follicular ulceration has taken place, and the prognosis becomes very grave.

Notwithstanding the ulceration that is going on, blood is not passed in large quantities, but mucus predominates. The stools are dark-green or brown, and the odor horribly offensive. The appetite fails entirely, and emaciation, with steady loss of weight is noted; the dry and parchment-like skin hanging in folds is very characteristic. In very bad cases bed sores form on the buttocks and heels. The mouth is very dry, and though the child has no appetite, thirst is intense. The tongue is dry and coated brown. In many cases which I have seen the urine is almost suppressed, and in all such cases always scanty, though I have never discovered albumin nor casts. A return of appetite and an increased secretion of urine are favorable symptoms.

Bad as are these symptoms, and sad a picture as such a case presents, I have seen them recover, though convalescence is very slow and tedious. Relapses occur upon the least imprudence in diet, and the intestines are often left in a delicate condition for months, and in one case which I recall, for a whole year.

The severest form of ileo-colitis, and one worthy of careful consideration, because of the necessity to differentiate between it and intussusception, is the membranous form.

The onset usually is sudden, with vomiting, frequent gushing stools and high fever, which is persistent, and ranges from 103° to 105°.

Signs of severe constitutional shock show themselves early. Prostration is an early symptom. Stupor and delirium occur so early in the disease at times as to cause an error in the diagnosis. The great distinguishing characteristic is in the stools, which are much like those of the catarrhal form of the disease, with the great distinguishing characteristic discharge of membrane. This membrane is not discharged in large sheets, but in shreds and patches.

This is the most fatal form of the disease, and probably but few infants survive an attack. The duration of the average case is two weeks, but I can recall one infant of eight months who lived but four days.

Treatment.—The most important consideration in treatment is that of diet, and as we have to do very frequently in these cases with an infant or child who has no appetite at all, the question is most vexing.

It may be stated that at the onset of the disease it is just as well to give no food at all for a few hours until an effort is made by the exhibition of the appropriate remedy or remedies to check the initial symptoms of vomiting and diarrhœa. In the case of older children who are being fed on broths, meats, etc., it is to be remembered as most important that their food be reduced in character appropriate for infants.

The great desideratum is to find food which will leave the smallest amount of residue. Cow's milk in any and all forms seems to be hurtful, according to observations of the majority of physicians, and it is best, therefore, to prohibit its use entirely, or in cases of very young infants, to skim the milk and peptonize it thoroughly.

Malted foods, recommended by some, I have found bad, because of their tendency to increase the number of the stools; and this objection holds good in this disease also to sweet and starchy food.

Beef juice, broths, liquid peptonoids, bovine and panopeptones I have found the most satisfactory foods to bridge over the acute symptoms, with very gradual return to the accustomed food, because of the great tendency to relapse.

Relapses occur from improper food, but also from changes in temperature, great fatigue and exhaustion; hence, not only is the food question one of great importance, but also the hygienic surroundings. A change of air is desirable so soon as the acute inflammatory symptoms subside. Sometimes it is advisable to send a child to the sea air, but my own experience favors the country or mountain air. Plenty of pure, fresh air is needed in all cases, and hence hospitals in crowded cities are not good places. The indications for bathing are the same as in any other feverish conditions.

Medical Treatment.—In the early stage of the disease any of the remedies for diarrhœa and vomiting may be called, and this remedy, together with the cutting down of the diet, may be all that is needed.

But so soon as the inflammatory symptoms show themselves,

and the characteristic symptoms of blood, bloody mucus, frequent and painful stools, accompanied by tenesmus occur, we find our remedies among such remedies as merc. sulph, merc. c. ipecac., aloes, etc., etc.

It is a question whether in the earliest stages a dose of castor oil—one drachm at six months, two drachms at one year, etc.—may not be beneficial to clear the bowel of any offending matter. In my practice I find it useful, but only in the earlier stages.

As an adjuvant to the above-named remedies and others of its kind, I have practiced with great satisfaction irrigation of the colon with tepid saline solution (common salt one drachm to water one pint). It should be injected high into the colon through a catheter or rectal tube, and repeated twice a day in the earlier stages. I have, when I had secured a good outflow, frequently used as much as a gallon at a time with good effect, but to get this the catheter must be introduced high up in the colon. In cases where tenesmus and bloody stools are abundant I have used the water as hot as 110° with great relief to the child.

At times it is well to use tinct. hamamelis or tincture calendula in the water injected, one-half ounce of whichever drug is used being the quantity to add to the pint of water. After the blood has been stopped and the stage of brownish-mucus stools has been reached, besides the regular remedies, such as merc., nitric acid, aloes, etc., etc., I have had the most success in the use of beta-naphthol bismuth in doses varying from grs. iij. to v. This can be readily given floated in water to any child every four hours or oftener, and combined with the irrigations, which should not be given so frequently as the case advances, has given me the greatest satisfaction.

Stimulants are needed in nearly all cases. Good whiskey, or better yet, when a good article can be procured, old brandy, given in doses of 30 drops to an infant of one year, will be found sufficient, the dose repeated every few hours, though in case of marked collapse, with weak pulse and poor circulation, as much as one drachm every two hours until reaction occurs, is useful.

As the case advances towards convalescence, the active symptoms having subsided and the stools having become less fre-

quent, the most important treatment is to continue the irrigations, and to take care that the diet of the child is of a kind that can be readily digested, and at this stage it is that a change of air is frequently so beneficial.

During the time of convalescence each advance that is made in the feeding should be gradual and watched with care, for fear of a relapse. Such remedies as may be indicated by the symptoms to act as tonics or tissue-builders be used. One rule in convalescence that I have insisted upon among those patients who can afford it, is to stay away from the cities until the autumn is so far advanced that no hot spell may occur.

EARLY DIAGNOSIS OF UTERINE CANCER.

BY W. LOUIS HARTMAN, M.D., SYRACUSE, N. Y.

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(Read before the Surgical and Gynecological Association of the American Institute of Homœopathy, Washington, D. C., June 18, 1900.)

THE subject which I have chosen for your consideration at this time is one about which the surgeon is eager to talk, hoping he may be able to find something more definite concerning the ætiology and curative treatment. We all dread to have patients affected with this disease enter our portals, as in the majority of cases we receive condemnation instead of reputation. The patients are not always willing to explain their condition to their neighbors whose ignorance is shown to our disadvantage, when the disease is in the advanced stage where nothing will stem the tide, and they are bound to float onward into the whirlpool from whence none are ever rescued. I do not think we are any wiser concerning the ætiology of this dreaded disease than we were twenty years ago, notwithstanding the fact that the State of New York has appropriated twenty-five thousand dollars annually for the last three years for the purpose, principally, I think, that our beloved brethren, the allopaths, can tell the people at large what they are not finding out about this great subject. My belief is and always has been, that traumatism is the great factor in the origin of this disease, let it be in the fundus or cervix.

It is not an uncommon thing to find a well-defined cicatrix in the fundus, if we take pains to look for it when the uterus is removed. Of course, we do not always find the disease in the lacerated part of the cervix as this is not always where the greatest injury has taken place during parturition. Ofttimes the bruising and crushing of the tissue is greater on the anterior portion of the cervix than where the rent has taken place. The posterior portion is not so liable to injury. I believe that obstetrical forceps injudiciously used are the cause of cervical carcinoma many times. We are too liable to take things for granted, more so than we have any right. The idea I mean to convey is, if we have some abnormal condition in the anterior portion of the cervix where bilateral laceration exists, where the cicatrix looks healthy, we are not liable to look upon the abnormal condition as one of a serious nature as readily as we would if it were in the laceration. Just at this point let me put in a word of warning, and that is, do not think that every nodule you find in the cervix is of a malignant character. You must remember that it is possible to have a mucous cyst in this vicinity. They are quite common and very hard to the touch, but by puncturing you will settle the question. Time forbids me to discuss the more common points which are so well known to all practitioners, but will take up those which are liable to go unobserved by those who do not have a large experience in this field of work.

It makes a great difference as to the location of the disease regarding the first symptoms, as sometimes portions of the uterus may become extensively involved and yet our attention is not called directly to them. If we have the anterior portion involved, my observation has been that we are liable to have, in 95 per cent. of our cases, a vesical irritation which may not be very severe perhaps, simply a disagreeable sensation. You will find this character of vesical irritation will not succumb to the ordinary remedial agents however, as there is a cause which must be removed before the disease or symptom is cured. This vesical irritation is merely a symptom and should always arouse our suspicions. This will usually precede the breaking down by something like six months, sometimes not as long, as you all know we may have cases of cancer of the uterus which will terminate life in less time than that. When you have this

symptom existing, it is your duty to obtain a specimen and subject it to a pathological examination, and determine whether or no you have a disease of the bladder to deal with or some grave uterine disease.

In most of these cases we will find a persistent leucorrhœa which has been of long standing and has not succumbed to the ordinary local applications and internal medication. This discharge may be in character from that of a deep yellow or greenish hue to a mere tenacious glarry mucus. My experience has differed from that of most writers, that as long as there is a glarry mucus discharge from the cervix, we need not look for malignant disease, as I have found carcinoma and sarcoma well advanced with this discharge existing, but the disease will be in the fundus, however. We also may find a profuse and inoffensive, watery discharge coming from the uterus and have malignancy well advanced.

It is not necessary to have either emaciation or cachexia to have malignancy well advanced, as a case which I saw a few days since, where the interior of the uterus, more particularly the cervix, was entirely broken down, but the patient's appearance was that of perfect health. Usually, where these conditions exist, the disease has advanced to a stage where treatment is of little avail, and if we do not remove the diseased portion our case will be numbered among the recurrent, for at this point we have systemic involvement.

Of course, we must take into consideration other diseases, such as erosion and ulceration of the cervix, where there is a breaking down which looks suspicious. A good way to differentiate between benign and malignant conditions is to apply a pledget of cotton saturated with a 10-per-cent. solution of cuprum sulphate. If it is malignant, it will have no effect upon it whatever. If it is of a benign nature, the chances are it will heal, or you will get some improvement within a few days. It is possible to find the disease in an advanced stage and it still have scarcely any odor—that which is regarded as characteristic. We must not rely too much upon pain, as it is absent in some cases up until the approach of death. Now, taking all these things into consideration, how are we going to make an early diagnosis? In the first place, if we have this persistent discharge of which I have spoken, that which is not

amenable to treatment, what naturally would be our suspicions at first? Adenoma would be one of the first things, and we would curette. Now, how much trouble is it to send a specimen of this to the pathologist, and let him determine whether or no this adenomatous growth is bordering on malignancy, or if we have endometritis to deal with? Ofttimes these growths will transform from benign to malignant several months before the uterus of itself has become involved. I believe this is due to the constant irritation and lack of proper nutrition, from the fact that they are constantly breaking down and causing a profuse and irritating discharge. If we were more careful and suspecting, and would endeavor to get at the pathological condition of uterine troubles, we would be more accurate than we are, and our percentage of cures in malignant diseases of this organ would be greater than they are at the present time.

When we have fibroids to deal with, and in the course of time get an inoffensive, watery discharge, we may rest assured it has transformed from that of a benign character to malignant. When we have suspicious conditions existing which baffle our skill (which has heretofore been sufficient to cope with apparently similar conditions), the paramount assistant is the microscope, and if we do not avail ourselves of its assistance, we are doing a great injustice to our poor and unsuspecting patients who have placed their lives in our hands and to our tender mercies. Until we have done this in all cases which baffle us and are of a peculiar nature, we are dishonest to the patient, the profession, and ourselves.

There is a time when carcinoma has a benign stage. Now, when I say this, what are the conclusions we should draw? The benign stage is that where infiltration of the surrounding tissue has not taken place; infection of the lymphatics in the immediate vicinity has not occurred; and at this point, if we do not use palliative treatment, but use radical measures, such as complete removal of the organ, we will in all probability prevent a return in any portion of the body.

I do not believe in high amputation of the cervix, as Byford advises. He says, if it recurs we can easily do a hysterectomy. Why take any such chances? A recurrence may go unobserved until it has reached the point where operative procedure is of no avail. The high amputation is what I deem palliative

treatment. Of course, if the disease has gone on to the stage where operation is of no avail, then the only thing to do is to make them as comfortable as possible, as thoroughly curetting the parts and applying local applications, it matters not much what, for none will stay the disease. Hold out no hope to the patients, and advise them to make peace with their Maker and prepare for that place from whence none have ever returned. The word "palliation" should be stricken from our vocabulary when discussing malignancy of the uterus or any other part of the body. Palliative treatment in the earlier stages should be discouraged in every possible way. If the patient will not submit to the operation, do not be guilty of taking a few paltry dollars from any victim who is suffering from this loathsome disease, for this would be dishonest to yourself as well as your patient. In all of these cases insist upon early operation, and do not say to the patient, "We will wait and see; a month from now will do as well as now." Always bear in mind that the penalty of procrastination is oftentimes the life of the individual.

As to the frequency of this disease in the fundus, I believe we get malignant disease involving that portion of the uterus more often than we have any idea. We may have the disease start in the upper portion and when first discovered is involving the cervix. I presume all operators have had the same experience that I have when removing the organ for cervical cancer and found the fundus extensively involved, also the adnexa. These are the cases where we get rapid recurrence. My experience bears me out in this statement, that two out of every five cases of malignant conditions of the uterus have their origin in the fundus. The reason we do not find many cases starting in the fundus is, that we do not use the curette and microscope freely enough, in fact, we do not look for the disease in that portion.

You will pardon me if I trespass upon your time in discussing the operative treatment. As I have said before, a complete hysterectomy is the only satisfactory way to deal with this malady. In the earlier stages, the removal of the uterus and its appendages will be sufficient, but if the case comes to you when infiltration has taken place, you are not justified in doing anything short of removing the uterus, its appendages and sur-

rounding lymphatics in order not to have an immediate return of the trouble and to give your patient the longest possible lease of life. Where the vagina has become involved, it is but little use to operate. If the operation is attempted at this stage of the trouble, in justice to ourselves, we should always inform the patient or her family of the possibility of a recurrence, and then they will be the ones who will take the chances—not the operator. It is always wise to make them understand in order to save your own reputation. Where the disease has involved the lymphatic glands, the only operation which is feasible, or where we may hope to attain any degree of success is the vagino-abdominal, as by the vaginal route we are unable to remove the pelvic glands or even discover them with any degree of certainty, and the additional time which is consumed in going through the abdomen will be very profitably spent, as it is absolutely the only way in which we are able to cope with the enlarged glands successfully.

The method I pursue with vaginal hysterectomy is not, perhaps, in keeping with those laid down in our text-books of today, or which many of the gentlemen present would consider good technique, but I have had most excellent results with this method. In a series of one hundred and fifty cases I have not had a death or secondary hæmorrhage following the operation. Where I differ from others is in the last part of the operation, and in ligating the arteries. I find that I cannot, with any degree of confidence, tie off a broad ligament with three ligatures. I do not limit myself to any number; sometimes I will use four or six on a side and sometimes many more. When I tie off the uterine and ovarian arteries I always use two ligatures on each vessel, place them from one-fourth to one-half inch apart as the case may admit. In doing this I am doubly fortified against hæmorrhage, as it would be an almost unheard of accident for both ligatures to break or give way.

In regard to closing the opening, I am averse to that and do not do it. I leave the wound open and pack it full of gauze. This I put in very firm, which not only shortens the operation, but will stop capillary oozing. This I leave until the third day, when I remove it, wipe out the cavity with sterile water and place a suppository of boroglyceride containing five grains of acetanilide. I do this twice daily until the fifth day, when I

use the douche instead of wiping, and place the suppository after. In using the douche first I prefer a soft rubber catheter so as not to injure the parts. In leaving the wound open and packing with gauze, there are several advantages. In the first place, we prevent all oozing, or if we do not prevent it, we have good drainage, and can prevent a clot in the pelvic cavity which will overcome future trouble. Second, it takes only about fifteen hours for the lymph to be thrown out, and we have a perfect cavity which we will be able to inspect and relieve any trouble which may arise from a possibly infected ligature. In this way our cavity acts as a safety-valve in case our ligatures give us any trouble, as when an abscess occurs it will break through into the pocket if you choose to call it such. If you have no such trouble, the wound will close and be healed sufficiently solid in time to allow your patient to get up as soon as she should after such an operation.

SOME REMARKS ON THE PATHOLOGY OF MYOPATHIC DYSTROPHY.

BY EDWIN H. VAN DEUSEN, M.D., PHILADELPHIA.

BOUCHARD five years ago made this statement: "There are four chief pathogenic processes: 1. Primary elementary dystrophies. 2. Nerve reactions. 3. Disturbances antecedent to nutrition; and, 4. Infection."

"The first of these processes is the most simple, but it is the least studied, and I may add that it is almost completely unknown. It is that which arises from the vital activity of cells when it is directly brought under our notice by some cause, physical, mechanical or chemical; from the lightning stroke to the intoxications, or by the way of traumatism."

This paper has to do especially with that form of progressive muscular paralysis where there is no discoverable primary lesion of the central or peripheral nerve-structures. The paper makes no pretense to solve mysteries, but is presented merely with a desire to attract attention to a subject which is so little studied, and, to quote again, "almost completely unknown."

The paralysis in myopathic dystrophies is not due to any defect in nervous energy, nor to any defect in the transmission

power of the nerves, but to a transformation of the muscular fibre into fatty tissue so gradually that the more or less completed process includes decades rather than years. There is only one symptom, and that is loss of power which is directly proportioned to the fatty metamorphosis. This fatty change occurs in both striated and unstriated muscular fibres. In the case of voluntary muscles the change is usually, perhaps always, bilaterally symmetrical; the extensor muscles are usually first affected, and continue more affected than the flexors. The nomenclature of the muscles of the leg makes an exception, which, however, is only apparent. The tibialis anticus fails first, and continues relatively weaker than the antagonizing gastrocnemius and soleus to the end of the case. Death takes place from inability of the heart muscle to fulfill the demands made upon it, no matter whether the burial certificate reads pneumonia, bronchitis, whooping-cough or what not. In advanced cases, macroscopically, the muscles look like masses of fat. They may, and usually do, retain their form, but an examination with the microscope may be necessary to discover any muscle fibre.

A paralysis quite naturally suggests a lesion of the nervous system.

A paralysis without a lesion of the nervous system is quite conceivable, for the performance of a muscle's function is dependent upon two factors, the absence of either of which inhibits the function. These factors are:

1. The inherent power to move, which resides in the muscle alone, and
2. The stimulus necessary to cause motion, which resides in the nervous system alone. (Chemical and mechanical causes of muscular contraction are not here considered, since they are not ordinarily operative.)

When the stimulus to motion is lacking, whether from failure of the central organ or from a solution of continuity of the transmitting nerve, the power of motion is lost, for muscles do not move of themselves, no matter how great their inherent power of motion. Furthermore, when the stimulus to motion is lacking the inherent power to move diminishes proportionally, for this power depends upon nutrition, and nutrition depends in part upon functional activity.

On the other hand, this question presents itself: Can the inherent power to move, residing in the muscle alone, be affected without a disturbance, either antecedent or consequent, of the organs supplying the stimulus? Can the muscle lose its power without any affection of the nervous system?

Well, why not?

Except that we are so accustomed to tracing every evidence of functional activity in the body back to the cerebro-spinal or sympathetic nervous systems, there is no *a priori* reason for a negative answer.

There are frequently-occurring illustrations of trophic changes in tissue entirely independent of any pathological condition of the nervous system. Without resulting from exercise we see a peculiarly large muscular development of certain portions of the body. Sometimes it is the calf and sometimes the thigh, sometimes the legs and sometimes the arms. In other instances, the fatty deposits are made very irregularly. You will find the women of one family with large arms and busts and small legs. In another family the women will have slim arms and an appearance of actual emaciation about the chest, and yet their legs will exceed all the standard artistic measurements. We have also seen men with enormously fat abdomens and rather slim legs. All the tissues partake of these vagaries. The variations in form and feature of individuals and families are almost as great as their number.

The fact that these are inherited peculiarities is no contradiction of the proposition that trophic changes, even to a pathological degree, take place independent of any pathological change in the nervous system. Our search for a cause of these trophic changes will bring us face to face with the existence in each ultimate cell of a something which we may call nutritive power, vital activity, vital energy, vital force, etc., but which is the something whose presence or absence is the final index of life or death.

The investigation of cell-nutrition does not require the theoretical acceptance of the existence of a system of trophic nerves and trophic nerve-centres. Such a system is, of course, not impossible, but if it exists at all, its function is probably to co-ordinate and not to inspire nutrition. The proper pabulum must be supplied, but the nutrition of the cell depends upon its

own inherent power of appropriating the material to its needs. Faulty cell-nutrition results from either one or both of two causes:

1. Supply of faulty material, or
2. Perverted nutritional power or vital activity.

Myopathic dystrophy, therefore, may be supposed to result from

1. Improper or imperfect blood supply, or
2. Perverted nutritional power in the muscle cells.

With this as a working hypothesis we may arrive at a reasonable treatment for the disease. It will take years, however, to demonstrate its success or failure.

Dietetically, the nitrogenous foods are to be selected and the hydro-carbons or carbo-hydrates, or both, if a distinction is made, are to be rejected.

Hygienically, exercise in the open air to the point of tolerance, with a special attention directed to affected parts, is to be recommended.

Medicinally, we are to select phosphorous or some such deeply-acting remedy capable of inducing changes in ultimate nutritional activity.

NEURASTHENIA.

BY AMOS J. GIVENS, M.D., STAMFORD HALL, STAMFORD, CONN.

(Read before the American Institute of Homœopathy, at Washington, D. C., June 22, 1900.)

PREVIOUS to 1868 this disease was recognized and described by English and French physicians at different times as spinal irritation, nervous marasmus, irritable weakness, cerebro-gastric disease, cerebro-cardiac-neuropathy and nervous asthenia. It was not really described as a disease, but rather as a group of diseases, until Dr. George M. Beard gave it the very significant and appropriate name of neurasthenia. Since that time it has become generally and universally known as such. At first it was called Beard's disease, but later, American nervousness. It is a disease of modern times that is increasing. It is an irritable weakness of the nervous system, resulting from the high pressure and erroneous methods of living and education

of the age, for these are times when people do not retire from business, but are ambitious and endure the wear and tear as long as they can.

Neurasthenia occurs about equally in both sexes, and more frequently among the intellectual classes—the brain-workers. It is seldom observed after the age of fifty or before the age of twenty. This is the most active period of life, and the time when the most nervous energy is utilized.

The causes, like those of mental or other diseases, may properly be divided into remote or predisposing and immediate or exciting. Probably heredity may be regarded as the greatest predisposing factor. The patient may inherit a feeble constitution, or may always have been nervous or subject to sick headaches. Careful inquiry may elicit the information that the patient's parents have had tuberculosis, syphilis or gout, or that the father was aged or a dipsomaniac, or that even consanguineous marriage existed. Any of these diseases or conditions in the ancestry have a tendency to create a degenerate and enfeebled state of the nervous system; a neuropathic state which is easily excited by a multitude of causes.

The exciting causes are numerous, and include every condition which utilizes nerve force and nervous vitality faster than it can be regained. Undoubtedly overwork and want of rest, burning the candle of life at both ends, are very important factors. Worry, grief, anxiety, social demands, late hours, wine, or any disease which exhausts the general system, may be the direct cause.

The reflex irritations are by no means to be overlooked. Eye-strain due to some error of refraction, such as astigmatism or hypermetropia or muscular insufficiencies, has caused untold misery in different individuals. Uterine displacements, laceration of the cervix, and rectal diseases like hæmorrhoids, fissures, pockets and papillæ, are sometimes a constant source of annoyance in a sensitive nervous person.

Still other causes may be observed, among which are urethral disorders, over-taxation of the genital organs, fright, sunstroke, great exposure, hardships and excesses.

The symptoms of neurasthenia are numerous and varied. They may be compared to the ever-changing manifestations of the kaleidoscope. No two patients are ever alike. Languor,

muscular weakness, inability and disinclination for exertion are usually observed. Defective nutrition and general debility are present in all cases.

The patient may be troubled with insomnia. Perhaps, after a hard day's work, he retires, expecting to get a good night's rest, and after sleeping an hour or two remains wide awake the remainder of the night, or possibly wakens at an early hour in the morning, after a few hours of dreamy, unrefreshing sleep. There is hyperæmia of the brain and an unstable condition of the vasomotor system due to deficiency of nerve-force. Headache may be a distressing symptom. A feeling of pressure on top of the head, or a sensation as if the head was going to open, is sometimes present, but usually the patient complains of pain or a dull, heavy ache in the occiput.

Noises in the ears are noticed, as the ringing of bells, rumbling, ticking, buzzing, or a sound of an explosive character may occur. Vertigo causes much uneasiness and anxiety. Recently a patient came under my observation who was troubled with dizziness and numbness in the extremities, together with cold feet, and he thought he was surely going to have an apoplectic seizure. He was alarmed, but did not realize that nervous exhaustion could create all these unnatural feelings. Sometimes the eyes are sensitive to light, the vision is blurred or asthenopia is marked, or spots appear before the eyes, or there is a loss of memory and an inability to think, to reason, or even concentrate the mind. Thickness of speech, mental depression, or even hypochondriasis, irritability and neuralgia are often met with in this disease. Even the secretions are abnormal, and the skin is dry and the urine scanty.

Years ago this disease was described as spinal irritation, because tenderness of the spine was frequently a prominent symptom. Digestion is poor and nervous or gastric dyspepsia is a troublesome feature with some cases. The functions of the liver are impaired; there is belching of wind and pain from fermentation of food, and usually constipation is present. The heart's action often causes anxiety. Palpitation, tachycardia, and weakness or irregularity, and even pseudo-angina pectoris, are observed in some patients.

Neurasthenic patients are sometimes troubled with morbid fears. They are afraid of being alone or in the dark, and have a fear of disease and an aversion to society.

One patient I knew could go about Stamford and do shopping and other things requiring energy and judgment, but could not go down the Main Street, but always passed through the side streets. Beard describes similar cases, and designates this morbid state as *topophobia*.

In the differential diagnosis of *neurasthenia* one must distinguish it from *anæmia*, *hypochondriasis*, organic diseases of the cord, and *paresis*; care must be exercised also that general debility, *nephritis*, or other diseases characterized by exhaustion and loss of strength, are not mistaken for it.

In *hysteria* we may observe paralysis and convulsions, contraction of muscles, anesthesia, *globus hystericus* and tenderness over the ovarian region. *Neurasthenia* comes on gradually and *hysteria* generally quickly. It is true, however, that *neurasthenia* and *hysteria* may be associated in the same patient. Then the diagnosis is more difficult. In the organic lesions of the cord we have lancinating pains, paralytic and girdle symptoms, contracted pupils which are irresponsive to light, and absence of patellar reflexes, but the *neurasthenic* patient can stand alone in the dark or with the eyes closed, and has none of these symptoms.

In *hypochondriasis* the delusions are fixed. The *neurasthenic* patient may believe he has brain or heart disease or gastritis, but the physician's visit temporarily dispels the morbid ideas and inspires hope. The *hypochondriac's* delusions are always present and perceptible. The history of some hereditary psychoses is usually found, upon careful inquiry. There is a vast difference between the simple depression of *neurasthenia* and *hypochondriasis*.

In *paresis* there is a perversion of the mental faculties, a psychic disturbance which is characterized by loss of judgment and reasoning power; a general emotional or excitable mental state is often apparent. The *neurasthenic* patient is always conscious of his condition and knows when he makes a mistake. The *paretic* patient is unconscious of mistakes and believes it is impossible for him to err.

The prognosis with proper treatment is favorable unless there is a hereditary history of nervous or mental disease. Such patients, as a rule, are restored to health.

In connection with the treatment it is always best to ascer-

tain the cause. If overwork, a simple case of brain-fag, then a rest, a vacation, a sea voyage, a change and a separation from anxieties and responsibilities will effect a cure. With more severe cases more thorough measures are necessary. Each case should be carefully individualized, their temperament and former methods of living considered, and a systematic course of treatment outlined and followed.

It is unwise to advise long walks, long rides on the bicycle, or work of any description. Rest is imperative. The rest cure as used by Dr. Weir Mitchell is often of great value. The patients ought to be informed that time and patience are essential for their restoration to health. Mild cases can be cared for at home. One of the most important features, however, of the rest treatment is quiet and rest in bed, a competent nurse, and isolation from kind, interested and too sympathetic relatives. In fact, when it is impossible for the patient to be free from too much sympathy, they are much better off with strangers.

All excesses, everything which exhausts the strength and tone of the system, should be avoided. All reflex irritations should be recognized. The stomach, pelvic organs, heart, kidneys, liver and eyes should be examined. All alcoholic stimulants, and even tea and coffee, should be let alone.

Most neurasthenic patients are anæmic and the quality of their blood should be improved. A special diet is essential, as digestion is often impaired. Some patients can only digest liquid food. The body contains a large percentage of water, and liquid food is often easily assimilated. The patients should be given all the food they can assimilate; nutrition should be improved, they should gain in weight, the impoverished nerve-centres nourished, and passive exercise in the form of massage utilized. Massage when properly given is very beneficial; the general movements towards the centre of the body imparts tone and strength. Hot milk is of as much value in promoting sleep in neurasthenia as it is in mental troubles. Oatmeal gruel, graham bread and fruit are excellent when constipation is present.

Hydrotherapy is an excellent thing in the treatment of some cases. The cold sponge every morning with salt water is invigorating, and keeps the skin in good condition to perform its function. The hot spinal douche followed by a cold spray is

beneficial and promotes nerve nutrition. A hot salt bath or a bath for half an hour in water at the temperature of 100° promotes sleep. General faradism, galvanism and static electricity are excellent adjuvants. The positive head, static breeze helps the headache and nervousness, overcomes insomnia and acts as an electro-tonic sedative.

The remedies indicated are numerous; and, as stated before, each case must be carefully individualized and the indicated remedy selected. Any remedy which has a tendency to nourish impoverished nerve centres or add general tone to the system will be beneficial. Among the medicines most frequently found to be of value are, kali phos., china, phosphoric acid, anacardium, argent. nit., phosphorous, strychnia, bell., gels., calc. carb., nux vom., ignatia, silicia, sepia, sulphur, pulsatilla, zincum phos., natrum sulph., and picric acid.

VARICES.

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(Read before the Philadelphia County Homœopathic Medical Society, March, 1900.)

THE term "Varices" is restricted to the veins of the extremities, notably the saphenous and its branches. Varices are dilated—tortuous and thickened veins. The disease begins by a gradual dilatation of the vein, its walls become thickened by inflammatory exudation, the endothelial lining becomes altered, and the valves, in consequence of the dilatation, are unable to support the column of blood this loss of valvular action causes—segmental dilatation and pouching. The middle and external coat also undergoes changes by a proliferation of connective-tissue cells, and inflammatory exudation. If the varices do not stand out above the level of the skin they are embedded in œdematous tissue, which is caused by passive exudation into the surrounding cellular tissue. This was called by Liston the "solid œdema," and differs from the œdema caused by a mechanical obstruction to the venous flow in that it does not pit on pressure, and the parts are glazed and tense.

An eczema often develops upon their surface, followed by

the formation of ulcers. If a rupture of the vein or an ulceration into the lumen occurs, it may give rise to a very troublesome hæmorrhage.

Thrombi may form in consequence of the altered endothelial lining and pouched condition, and these clots often break down and form abscesses, as in suppurative thrombo-phlebitis, or it may organize and occlude the lumen, as in plastic-thrombo-phlebitis.

The thrombi may shrink and layers of fibrin be deposited, and so occlude the vessels. In addition, phosphates of calcium and the sulphates of calcium and potassium are deposited, so that typical calculi may be formed, known as "vein stones" or "phleboliths."

In all cases of varicosity Gray has pointed out the chemical fact that "the general circulation has been subject to a very considerable and long-standing embarrassment." The disease is most frequently seen in the female and persons of advanced years. This, however, is not the constant rule, as we have frequently seen this condition in comparatively young people. Obstructions in the form of tight lacing and the wearing of garters, those who are habitually required to stand, all varieties of abdominal and pelvic tumors, diseases of the heart and lungs, are some of the predisposing and exciting causes.

The palliative treatment consists in attention to the general health and support of the limb; the uniform pressure of the roller bandage is better than any finely-made elastic stocking, and has many advantages. In the treatment of varicose ulcers, rest is the prime factor, a good blood supply, asepsis, stimulating, and later cicatrizing, dusting-powder and skin-grafting. These ulcers are a bugbear to the surgeon. A prominent surgeon once said, "I judge a man by his ability to heal a varicose ulcer."

The radical treatment should be undertaken early, before this distressing condition arises. Numerous methods have been devised, and they all have for their object the complete obliteration of the vein. The two methods worthy of consideration are, first, that of complete excision devised by Celsus, and later perfected and performed by Colley and Marshall; the other that of Phelps—based on the principle of "entire occlusion of the whole length of the affected vein." He applies

numerous ligatures to the vein, in some cases as many as eighty, at intervals of one inch. The application of a rigid antiseptic technique is absolutely necessary. The operation consists in a series of subcutaneous ligations, by means of a straight flattened needle with an eye in the point. The needle is threaded, preferably with fine catgut, and passed immediately behind the vein; the needle is then unthreaded and withdrawn; it is again introduced through the first opening, passed in front of the vein, and allowed to emerge through the corresponding puncture in the skin; the end of the ligature is again threaded, the needle withdrawn, the ligature tied, and the knot allowed to slip beneath the skin. Cases in which this operation is applicable may be classified:

1. Cases where this constitutes disability in physical examination.
2. Cases in which there is a threatened hæmorrhage.
3. Cases of existing ulcerations or eczema.
4. Cases with a troublesome œdema and disability.

TREATMENT OF PNEUMONIA.

BY E. L. HINMAN, M.D., OSWEGO, N.Y.

(Read before the Central N. Y. Medico-Chirurgical Society, at Syracuse, December 7, 1899.)

PNEUMONIA is an inflammatory process affecting the true lung-tissue. The different varieties—croupous, catarrhal, septic, secondary, lobar, etc., are to-day treated in very much the same manner, so far as external means are concerned, and only slight deviation as regards internal medication.

The very first thing the physician should do, in every case, is to see that the patient is put to bed with at least one woolen blanket as a covering. This woolen blanket will keep many a mild case from contracting more cold, and it can be borne even in summer. In winter this will necessitate less of the heavier coverings, which make the patient so uncomfortable.

The next thing is to get some good, competent nurse—one who understands taking the pulse, respiration, and temperature, unless you intend visiting the patient very often. The patient

must not leave the bed, even to go to the closet or sit on the commode, as he runs great risk of taking cold. This must be *insisted* upon in every case, and with proper accessory treatment the mortality of your pneumonia cases will be reduced to a minimum. I believe that half of the so-called complications of pneumonia are from undue exposure during the early stages of the disease, even after the physician has charge of the case. I believe in the early administration of "stimulants," but not alcoholics. I almost invariably give from the very beginning $\frac{1}{50}$ gr. sul. strych. every six hours until about the crisis, then $\frac{1}{30}$ gr. at the same intervals. This mode of treatment is throwing up the breastworks in preparation for the array of battle. It is a poor time to get ready for the crisis when it is upon you. A little forethought on the part of the physician will enable you to carry your patient almost invariably through this, the worst part of this critical disease. For the relief of pain, I regard the use of morphine as decidedly dangerous, as it has a depressing effect upon the heart, and causes congestion to the already congested and inflamed lung-tissue. A solution of the pure oil of mustard, with alcohol, in the proportion of 1 to 32, painted over the lungs, both anteriorly and posteriorly, will relieve any severe pain very promptly, acting, as it does, as a counter-irritant.

This I regard as far superior to the old-fashioned use of *o* iodine, and is much cleaner in appearance, and will not blister nor leave surface of skin sore and sensitive. This should be applied 3 to 6 times every 24 hours, according to severity of case, and always with a camel's-hair brush, or an improvised one. This will keep the hands of the nurse free from coming in contact with the solution, as the fumes arising from it during its administration usually make the eyes "water," and the most natural thing to do is to rub them. This solution coming in direct contact with the conjunctiva would cause a violent inflammation of that membrane. A few seconds after the application is put on there should be a severe burning sensation over the entire surface covered, lasting but a minute or two, then another painting of the surface, and so on for four or five times at each application.

You will be surprised to see how quickly all pains and aches subside, the heart beats steadier, the patient is less nervous, and everything will progress in a much more rapid manner.

The bowels should be carefully looked after, and be kept "free and easy" from the beginning, as pneumonia is a toxæmic disease, and therefore requires free action of all the excretory organs of the body. The stomach should be favored as much as possible. Avoid overloading even with light food. "Little and often" should invariably be the rule, the food being either liquid or semi-solid, and as nutritious as possible. I believe the likes and dislikes of the patient regarding this very important part of the treatment should be heeded, as food will do him more good if it is relished.

Three-fourths of the complications of pneumonia are due to improper action of the organs comprising the alimentary canal, together with liver, kidneys and skin, or from getting chilled from undue exposure in the sick-room. If constipation exists even to a slight degree, and the patient is not too weak, give enemias of warm salt water regularly once or twice each day. This will not only relieve the colon and rectum of fecal matter, but will promote a healthy and vigorous action of the kidneys.

There are many local measures in more or less common use to-day, viz.: Poultices of different kinds, moist, dry, cold and hot. Then we have the simple oil silk with absorbent cotton jacket, different blisters, and lastly the cold coil and ice bags.

I have little or no use for the ice treatment in this disease. Experience in the treatment of a large number of critical cases, cases given up by other physicians, especially of the allopathic school, has demonstrated to me that keeping the surface of the chest *naturally* warm, reducing the temperature by internal administration of remedies, will bring the greatest number of cases through. Aconite judiciously used, but only when indicated, at any or all stages of the disease, will almost always control fever, especially if used in conjunction with bell.

Although poultices are disagreeable, and there is more or less danger of exposure of the wet surface between application, I will give you the formula of one that I never knew to fail to give prompt relief.

Take six to ten onions, according to size, and chop fine, put in large spider over the fire, then add about the same quantity of rye meal and vinegar enough to form a thick paste. In the meanwhile stir it thoroughly, letting it simmer 5 or 10 min-

utes. Then put it into a cotton bag large enough to cover the lungs, and apply to the chest as hot as the patient can bear. When this gets cool apply another, and then continue by reheating the poultices, and in a few hours the patient will usually be out of danger, regardless of the severity of the disease. Usually 3 or 4 applications are sufficient, but you must continue until perspiration starts freely from the chest. The chief object sought in the treatment of pneumonia is the equalization and restoration of the circulation.

"Kadlin," or antiphogistine, is another local application which certainly deserves place in this paper. Those of you who have become familiar with its use as an outward application over the site of any inflammation, can testify to the remarkable results obtained oftentimes from this product of mother earth, and I think you will join with me in placing it at least *among* the best outward means-of-relief in the treatment of pneumonia. Coming, as it does, from the native soil of Colorado, being ground to a non-irritating mass containing glycerine, boracic acid, salicylic acid and iodine, combined with the vehicle dehydrated silicate of magnesia. This substance has a powerful affinity for water, and when applied to the skin abstracts large quantities of liquor sanguinis from the tissues, thus relieving the congestion and inflammation and equalizing and restoring the circulation. Its application once a day is usually sufficient. For excessive temperature which yields *stubbornly* to internal treatment, try sponging the chest with tepid or hot soda water, and the result will be very gratifying. As to the *internal* treatment of pneumonia, I would say: No set rule can be laid down, as we have to study carefully our materia medica and our individual patients for the indicated remedy.

I would, however, suggest a remedy coming as near a specific (a remedy for every case of pneumonia) as any remedy can. This remedy I regard of more actual value than any other one remedy in the entire materia medica in the treatment of this disease. I use it from the first day to the last, however mild or severe the case, with very gratifying results. That remedy is iodine 2x, made invariably from the homœopathic mother θ , as the ordinary commercial, or U. S. P., is unreliable. I usually saturate disks with this 2x dilution, giving 2 or 3

every 15 minutes to an hour, letting them dissolve in the mouth and throat, thus getting the local effect of the drug. This local effect of iodine I regard as the most important action in pneumonia. The constitutional being very remote and only through the blood. I have known of cases in patients who have passed their 50th and 60th birthdays, with respiration over 60 per minute, and temperature over 105° , respond quite readily to the iodine treatment with the other indicated remedies. These other remedies are necessary, and must be used when indicated, but I regard iodine as always indicated in pneumonia.

Veratrum viride is an excellent remedy as a reducer of the pulse and temperature. *Digitalis* and *strophantus*, with strychnine or arsenicum, are reliable heart tonics, and are preferable to alcoholics, which have so many bad after effects. These tonics should be used from the 5th to the 12th day in ordinary protracted cases. Protoneuclein is another remedy whose administration is usually attended with excellent results. Its proprietor's claim for it is that it antidotes the toxæmic elements of the blood, reduces the temperature and stimulates the patient. We cannot but acknowledge that the apparant action, judging from the results obtained, but simulate these characteristics.

THE OCULAR SYMPTOMS OF TABES DORSALIS.

BY W. H. LYLE, M.D., PHILADELPHIA.

(Read before the W. B. Van Lennep Clinical Club, May 1, 1900.)

THE object of this short paper is to emphasize the importance of the eye symptoms of locomotor ataxia. We are all familiar with such classic symptoms as the loss of the knee-jerks, the static ataxia and the lightning pains as they occur in fully developed cases, but few realize that in from 10 to 15 per cent. of these patients ocular changes precede all other symptoms.

According to the classification of Bevan Lewis, whose study of the disorders of the ocular movements in parietic dementia applies equally well to tabes dorsalis, these symptoms form a highly significant group. Both the extrinsic and the intrinsic muscles are involved. The most frequent derangements are as follows:

1. Spastic myosis; 2. Paralytic mydriasis; 3. All degrees of irregularity of pupil; 4. Irregular contour from partial spasm or paralysis; 5. Loss of sympathetic reflex; 6. Loss of consensual movements; 7. Reflex iridoplegia (Argyll-Robertson pupil); 8. Associative iridoplegia; 9. Cycloplegia.

Instead of following this classification, however, I shall discuss only those ocular changes which on account of their frequency seem most important to an early diagnosis. Myosis is the usual state of the ataxic's pupil. It may be either spastic, due to irritation, or paralytic in form. It is generally considered to be the latter, and is due to disease of the cilio-spinal centre in the lower cervical and upper dorsal region of the cord, or to disease at the origin of the pupil-dilating fibres found in the front part of the aqueduct of Sylvius. At times this myosis is of extreme degree, forming what is called a "pin-hole pupil," yet at the same time the pupil may react to light and on convergence. Mydriasis is seldom found in tabes except in connection with ophthalmoplegia.

A very important and familiar symptom of tabes is the reflex iridoplegia (Argyll-Robertson pupil), the condition in which the pupil does not contract when light strikes the eye, although it does contract strongly to accommodation. The best method of testing for this reflex iridoplegia is to place the patient facing the window. The physician, standing in front, covers the patient's eyes with both hands, the eyes remaining open all the time. After waiting for about ten seconds he takes away one hand at a time and observes the action of the pupil. If this method does not prove satisfactory, especially when there is a very dark iris, place the patient in a dark room and examine his eyes with reflex light while he is looking at a distant point. Then, if the iris does not respond to light, test for contraction to convergence. This is best done by getting the patient to look first at a distant object and then at a finger held just in front of his face.

Reflex iridoplegia is generally bilateral, but it may be unilateral. It is found in three-fourths of the tabetic patients.

Erb, in examining 84 cases, found that 59 had this Argyll-Robertson pupil, 12 very sluggish and imperfect reaction to light, and 13 had normal light reaction. The symptom is one of those most regularly found in posterior scleroses. It is very

often an early or initial symptom, and it may be the only symptom. It persists through all the stages of the disease. Its great value as a very early diagnostic sign is not fully appreciated. Often the first symptom of tabes which brings the patient to his physician is paralysis of the eye muscles (diplopia). The majority of all ocular paralyses occurring in adults are of tabetic origin. This is frequently overlooked, because the paralysis is often transient. The earlier the paralyses develop the more transient they are, and for this reason they are attributed to syphilis or rheumatism. Especially is this apt to be so if the paralysis disappears after a few weeks' treatment.

Syphilis alone is undoubtedly the cause in some patients, but in that case it is apt to be accompanied by pain. The transient form finally passes into the permanent paralysis.

The more extensive the paralysis the greater the probability that it will not entirely disappear. The sixth nerve seems to be the one most affected. The third nerve is often paralyzed also, and in that case the levator palpebræ superioris may be first involved, with consequent ptosis.

If only one eye is affected, it is surprising how the corresponding muscles of the other eye will show weakness from any extensive use. Ptosis is often present either in one or both eyes. The ophthalmoplegia most frequently affects the external rectus muscles, but at times the internal or superior oblique is involved. This progressive ophthalmoplegia is the most important form of the permanent ocular palsies of tabes.

Ocular ataxy is found at times, but is not a common symptom. It consists in an oscillatory movement which occurs only when the eye is under strain. It has frequently been mistaken for nystagmus; but nystagmus is a constant oscillatory motion of the eye-ball both while at rest and when fixed on an object, and is very rarely found in tabes.

Atrophy of the optic nerve is certainly the gravest symptom of this serious disease, and unfortunately it occurs in about 20 per cent. of the cases. It is more frequently found in the pre-ataxic stage; in fact it may be the only symptom, preceding the loss of knee-jerk, the lightning pains and the other spinal symptoms, by a long period of time, even from two to ten years. Frequently the occurrence of atrophy of the optic nerve in the pre-ataxic stage seems to have a beneficial influence on the spinal disease, the progress of the latter being retarded.

Optic atrophy usually affects both eyes within a very short time, although occasionally one eye precedes the other by a long interval. These patients frequently complain at first of slight photophobia, with bright light before the eyes and *muscæ volitantes*, these symptoms preceding the amaurosis by from one to ten years.

There is always some disturbance of vision in optic atrophy, not only of direct vision, but of the visual field. The latter is diminished, a concentric contraction being most frequent. Color-blindness occurs early, first for red and green, and later for blue, that color being recognized longest.

Of the ophthalmoscopic appearance of the disc during the very early stage of optic atrophy we can say little. Opportunities for its observation have been few. Those who have made a careful study of the optic nerve in this condition claim, however, that the atrophy begins at the periphery, and extends towards the axis of the nerve.

The normal pinkish color gradually changes to a gray, with atropic cupping. When the case is one of long standing, connective tissue is developed in the lamina cribrosa, and the nerve becomes glistening white in color, and the retinal vessels are almost obliterated. Between the remains of the nerve-fibres are found cells filled with granules of fat; symptoms of inflammation proper, however, are wanting.

I have dwelt upon these symptoms, not because any one occurs daily in practice, but because it is important that the physician, when he does meet one of them, should remember its significance. These ocular changes are rarely primary, rarely uncomplicated; they are, instead, but symptoms, often, of a horrible disease. We cannot, to be sure, cure locomotor ataxia; but with care we may check its full development. Remember, on that account, the possible importance of every ocular symptom.

A RING PESSARY GROWN OVER IN THE VAGINA (Frank).—The pessary had not been removed for two years. There had been considerable ulceration in the vagina, and the latter had cicatrized over the left side of the pessary. The latter had to be sawn apart to remove it. The cicatrix held the uterus up so that further support was unnecessary.—*Munchener Med. Wochenschrift*, 1898, No. 44.

THE WIDAL REACTION.

BY O. H. PAXSON, M.D., PHILADELPHIA.

(Read before the Saturday Night Club of Microscopists of Philadelphia, March 17, 1900.)

THE bacillus typhosus discovered by Eberth, and subsequently isolated in pure culture by Gaffky, is now generally recognized as the ætiological factor in the production of typhoid fever. It is a bacillus about three times as long as it is broad, and with rounded ends.

As we see it to-night in bouillon culture, with a one-sixth objective, it appears as short ovals or in long threads, these forms occurring separately or together. It is very actively motile.

Its morphology presents so little that will enable it to be identified that many efforts have been made to discover specific reactions for this organism; and with this object in view, many methods have been devised for its isolation from water, fæces, sewage and other matters believed to contain it. None of these, however, has given general satisfaction, and many have proved wholly untrustworthy. Those worthy of some degree of confidence are by culture-growths.

In cultures the bacillus typhosus is so variable in many of its biological peculiarities, and is so closely simulated in certain respects by a group of other organisms to which it appears to be botanically-related, that its identification, especially outside the infected body, is usually a matter of considerable difficulty and uncertainty.

The bacilli commonly found in fæces, sewage and infected water, which we have to differentiate from the typhoid bacilli, are the colon bacilli and the saprophytic bacteria. Even in the stools of typhoid-fever patients the presence of these normal inhabitants of the intestinal tract renders the isolation of the typhoid organisms somewhat troublesome. These are differentiated from one another by careful and tedious culture-tests, and by the macroscopic and microscopic character of their colonies. Colon bacilli colonies are easily mistaken for those

of the typhoid bacilli. The spleen of a patient dead of typhoid fever is the most reliable source from which to obtain cultures of the typhoid bacillus for study.

Having obtained a pure culture of the bacillus typhosus upon agar-agar, the next step is to remove, with a sterile platinum loop, some of this culture and introduce it into a test-tube containing sterile bouillon. It will be ready for use in twenty-four hours. It grows at any temperature between 70° and 102° F., though more favorably at the latter point. The specimen shown this evening has been grown at a temperature of 68° to 72° F., the lower temperature favoring a greater length and a more regular gliding motion that renders it more easy to follow the individual cells under the microscope than when they possess the usual active darting motion.

Widal's reaction is a reaction obtained by adding or mixing the blood-serum from a person having typhoid fever with a culture of the bacillus typhosus, the result being the cessation of motion, with clumping or agglutination of the bacilli.

The blood-serum used may be from freshly-drawn blood or from dried blood upon paper, as we are using this evening, as suggested by Wyatt Johnson of Montreal. The latter method is the only one practicable in a laboratory doing public work, as in the municipal laboratory of this city in connection with the Health Department. In the dried-blood method a drop of the blood to be tested, obtained by a needle-prick in the cleansed finger or lobe of the ear, is collected on a piece of paper and allowed to dry. With a medium size platinum-wire loop a drop of sterile bouillon, water or physiological salt solution is gently rubbed upon the drop of dried blood until the contents of the loop are of a dark amber color; this is then mixed with a drop of bouillon of typhoid bacilli on a cover-glass which is mounted upon the cell-slide as a hanging-drop, when the effect of the diluted blood upon the culture can be observed with the microscope.

This reaction, if possible, should occur within a half hour, and consists of a peculiar alteration in the relation of the organisms to one another in the fluid. As ordinarily seen in a hanging-drop of bouillon, the typhoid bacilli appear as single actively-motile cells. When to such a culture a drop of dilute serum from a case of typhoid fever is added, the motility

of the organisms gradually becomes lessened, and finally ceases, and the bacteria congregate in larger or smaller clumps.

Many object to this, the dry method, because it is impossible to dilute the blood accurately. It has been shown, though, by a number of tests, that preparations made in this way correspond roughly with a fresh-blood dilution of from 1 to 15 to 1 to 20, as determined by the hæmaglobinometer. Abbott is of the opinion that in doubtful cases, in which all the available clinical evidence is opposed to either the positive or negative results of the test, the difficulty is much more certainly cleared away by the use of highly and exactly diluted fresh serum than by this the dry method.

Wherever the Widal reaction for the diagnosis of typhoid fever has been carefully employed, the results are reported to have been almost uniformly satisfactory.

In the great majority of cases the reaction is, so far as experience indicates, specific—that is, a typical reaction does not occur between typhoid serum and organisms other than the typhoid bacillus, nor between the typhoid bacillus serums other than those of typhoid fever. There are, however, confusing reactions in which more or less clumping of the bacilli and a diminution of motion without complete cessation are observed.

Normal blood, blood from other febrile conditions, the blood of certain animals, as well as a number of chemical substances in high dilution, cause agglutination; but the action is not specific, for in most cases they have the same effect on other motile bacilli. Although the method is yet in the experimental stage, and there are still numerous features not entirely clear, it is fair presumptive evidence that the serum is from a case of typhoid fever when unmistakable agglutination and cessation of motion are seen in from fifteen to twenty minutes after typhoid bacilli are mixed with the serum of a suspicious febrile condition. Abbott reports, in an examination of ten to twelve thousand cases of typhoid and other febrile conditions, a discrepancy of only two to three per cent. between the clinical and laboratory diagnosis.

The importance of the peculiarities of the cultures employed is mentioned by Weaver. He has used both the wet and the dry method, and four cultures of different degrees of virulence.

In thirty cases of typhoid fever, in which he used the serum, twenty-seven were positive and three doubtful. In each of these cases only a single specimen of blood was examined. In twenty-nine cases, where the test was made with dried blood, nineteen were positive, eight doubtful and two negative. He says that complete loss of motion after a preparation made with strong serum has been kept for from sixteen to twenty hours, providing the culture is old and non-virulent, indicates the existence of typhoid fever.

When made with dried blood, the test is less accurate than with fresh serum.

Cave, in carrying out the Widal test, usually applies dilutions of serum of from 1-10, 1-30, and often 1-50.

In thirty-two cases of typhoid fever he has never failed to get the reaction, and usually early in the second week. He has never obtained the reaction except in actual or recent typhoid fever, and he therefore considers it of great diagnostic value.

Dr. Nogeli, assistant physician at Professor Sahli's clinic at Berne, has published an interesting account of a typhoid-fever epidemic which broke out in a pauper asylum of the Canton of Berne.

He says the Widal reaction secures the reaction diagnosis of typhoid fever even months after the patient has quite recovered from his slight symptoms.

Kasel and Mann do not think that the method permits an early unequivocal diagnosis of the disease, and are of the opinion that the contrary views of authors are based on inaccuracy of technique.

They look upon the reaction as an immunity reaction, and not as a reaction of infection, as assumed by Widal. They observed that the cases with a relative slowing of the pulse showed in general a more marked agglutination. There appeared to be no relation between the gravity of the infection and the height of the fever, on the one hand, and the time of appearance and intensity of agglutination on the other. If the strength of the fever is compared with the strength of the reaction in cases of like severity, it is found that those presenting a strong agglutination are shorter in duration than those which are weak.

It may be said, then, that the stronger the reaction, due attention being given to the severity of the case, the more favorable is the prognosis. In a test of fifty-one cases who had had typhoid fever, the reaction was positive in twenty cases during the first year after the fever, one each after fourteen, fifteen and a half and seventeen months, and three after four and a half, two after four and three-quarters, and one each after five, ten, fifteen and twenty-one years.

If the reaction is strongly positive in a suspected case of typhoid fever, it is more likely due to the present illness than to a former attack. The reaction was not found to persist longer after a severe than after a mild attack of the typhoid fever.

They consider it a most reliable sign in the diagnosis of typhoid fever in children.

Simon regards the Widal test as a most valuable aid in the diagnosis of typhoid fever, but open to several objections: First, it may be altogether absent in true cases of typhoid fever; this, however, is rarely the case; second, the reaction may not be obtained before the end of the third week, or may even be delayed until a relapse occurs; third, a positive result may be reached even after months and years following an attack of typhoid fever; fourth, there are cases in which immunity against the disease apparently exists, and in which distinct agglutination and loss of motility are observed in healthy individuals who have never passed through any serious illness; fifth, the reaction has been observed in various other diseases. The number of such cases is small, and it is quite likely that future investigations will show that the positive results obtained are referable to some error of technique.

Only a positive result, however, is of value.

THE REMOTE RESULTS OF BILATERAL REMOVAL OF THE ADNEXA.—Baruch.—The final results are less favorable in those cases where the uterus is not removed than after the radical operation, *i.e.*, removal of uterus and appendages. This is due chiefly to:—

1. Recurrent, painful inflammations in the ligated stumps, causing stump exudates, which are seldom observed after the radical operation.

2. Hæmorrhage from the uterus left in the pelvis.

3. Climacteric disturbances are less when the uterus is removed.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. xlii., H. 2, 1900.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

ONE USE OF STATE BOARDS OF EXAMINERS.

"SWEET are the uses of adversity," said Shakespeare, long ago. Perhaps in the future some as yet unborn poet, fired with a retrospective imagination and filled with the divine afflatus, may sing the uses of the State Boards of Examiners; the time is not yet ripe for such flights of fancy. "It's a' a muddle," as poor Adam Bede would say.

The Boards were ostensibly established for the purpose of protecting the public from incompetent practitioners, but the late case of a victim of the starvation cure, here in the city of Philadelphia, brought out the public statements from prominent members of the State Boards that the prosecution of unauthorized practitioners, such as the one under whose ignorant cult the confiding woman fell a victim, "did not belong to the business of the State Boards." "The State Boards have other work to do, and this is without their province." "If the members of the State Boards undertook it, they would have time for nothing else." (Whether this would be an unmixed evil is questionable.)

We have, therefore, this condition of affairs confronting us: The Boards, created for the protection of the public, feel compelled to limit their labors to the rooting out of possible incompetents from amongst those who have conscientiously endeavored to acquire a medical education, and whose general fitness to practice medicine and surgery is testified to by diplomas of chartered institutions in good standing, while the much more dangerous class of the entirely ignorant practitioners are "not within their province."

As was pointed out by the president of the allopathic State Board during the ephemeral excitement aroused by the case of starvation above alluded to, the law of 1897 was made to include as a practitioner "any one proposing to cure by the

use of any medicine, means or agency whatsoever, with or without remuneration," and yet with none of these practitioners, except those who have passed through a medical college, have the State Boards anything to do. It does look as if the medical colleges, and not the safety and welfare of the dear public, were the objects aimed at.

But we gladly leave this rather confusing view of the duties of State Boards and turn to a very definite use to which an attempt has been made to put the results of their action. As will be seen from another part of this journal, a grandiloquent misrepresentation of the results of an examination before our Board in this State was made use of in the announcement of a Western college as evidence of "the thorough work" done in that college, contrasted with that done in the others. The Board has in its communication, in justice to the other colleges, shown how utterly at variance with the truth were the statements made in the aforesaid announcement. It has acted wisely and justly, and deserves the thanks of the other colleges, which should not have been allowed to rest under the stigma of incompetency put upon them by their brother in the West. We wish to go somewhat further, however, and condemn *in toto* the use of anything connected with the Board, its members, its actions, or the results of its examinations, as means of advertising individuals or institutions. There is too much advertising done in connection with our profession to be in accord with the spirit of the code of ethics, and so long as this code is supposed to be in force, any attempt to violate its true intention should be frowned down. There are, however, so many ways in which its requirements in this respect may be evaded, and the devil whipped around the stump, that it has often seemed to us that the sooner all restrictions were removed, the better. It would, in many respects, be a sad day for the profession of medicine to be degraded from its high traditional position; to be reduced from a profession to a trade; to be thrown open to the practice of all the devices known to pure commercialism. It could not but be distasteful to many of us; and yet when we see how this very thing is being done, little by little but insidiously, by many of those who are publicly most loud-mouthed in their advocacy of the code, we think that fair play and common justice should either

demand the sure and swift punishment of every form of advertising, be it never so craftily effected, or should throw open to the ingenuity and business capacity of each the whole field of advertising so universally and thoroughly cultivated by the trade spirit of the day. Inasmuch, however, as the code is still supposed to be operative, we deem worthy of censure such a form of advertising the merits of a particular college as the one referred to above.

We all remember the curious entries in the diary of a young lady on a voyage to Europe made on consecutive days: "May 30, took a pill. May 31, passed an iceberg." This announcement is similar: "Took a course of instruction at ——— College, ———. Passed the State Board of Pennsylvania." It will hardly be necessary to draw attention to the striking points of similarity. We will say that there is as much logical connection between the two events in the second case as there is in the first, no matter how we interpret them, while the humorous aspect of the first can easily be transferred to the second.

We are sorry that the budding college should have felt impelled to resort to this form of making its merits known. The unusual character of the event heralded offered, no doubt, a strong temptation, but might and should have been resisted. Aside from the glaring misrepresentation of the facts, it was "not in good form." It is like the "unsought testimonial" to the merits of some patent medicine, advertising both parties, and presupposing that the one giving the testimonial will be universally regarded as competent to pass judgment, and that the judgment, when passed, will be looked upon as sound and conclusive.

Another point of view brings into prominence a serious danger, should it become the general practice to judge of the standard of a college by the number of its graduates able successfully to pass the examinations of the Boards. It would foster the tendency to modify and to adapt the instruction in the colleges to the supposed requirements of the State Boards. Now the question naturally arises, which of the two parties, the Board or the teachers, is best fitted to know what constitutes a true, thoroughly rounded medical education—one which shall fit its possessor to practice medicine without running into too close and dangerous competition with the "unauthorized prac-

tioners" with whom the Boards have no concern? So long as the colleges retain their charters, just so long have they their chartered rights, and just so long should these be maintained. To the teachers belongs the inalienable right to decide what is to be taught, and how it is to be taught. A willingness to depart from their conscientious views on these points in order to make a good showing before the examining boards, the same to be used thereafter as an advertisement, is a sign of reprehensible weakness. We do not mean to imply that this was the case with the Western college referred to, but we point to it as a very probable consequence of the course inaugurated by it. In view of the growing inclination of the Medical Councils to pose as the only advocates of a higher standard of medical education, and to seek to absorb more and more of the rights which historically and logically belong to the colleges, we cannot sufficiently emphasize the necessity, yea, the imperative duty of the latter to preserve their entire independence as educational institutions, if they would not become mere tails to the State Board kites.

A CASE OF LATE HEREDITARY SYPHILIS WITH A PARTICULARLY SERIOUS COURSE.—Dr. J. Sedziak observed a girl of 15 years who was debilitated and miserable, presented enlargement of the cervical glands with coryza, especially of the left nostril; the disease had begun two years before with swellings of the lymph-glands. On examination, a large, indolent and indurated swelling was noted on the left side of the neck; no fever. At the apex of the right lung there was prolonged inspiration. Deep in the left nostril there was denuded bone with ozena; in the posterior pharynx there were traces of Luschka's gland, which were covered with a greenish, dirty-colored exudate, dense and foetid. Towards the middle of the hard palate there was an ulcer one cm. in diameter, covered with a dirty coat (denuded bone). Besides, there were sclerous keratitis and cataracta accreta of both eyes.

The diagnosis lay between a lympho-sarcoma, tuberculosis and syphilis. The first two being eliminated, energetic specific treatment was instituted, which was followed by complete success. Two facts were noted: The efficacy of the method "ex juvantibus," and the tolerance of a very delicate organism to iodic and mercurial preparations. The appearance of hereditary syphilitic manifestations so late in life and in so grave a form were curious.—*Przegląd Chirurgiczny*, Tom. iv., Zeszyt 3, 1900.—(Dr. Donner, of Stuttgart, has written a very good little work on "Late Hereditary Syphilis, with its Homœopathic Treatment." It is in German. Some of his cases make very instructive reading, for he is a good diagnostician.)

GLEANINGS.

CANCER OF THE LIPS.—Dr. Fricke, from a study of 137 cases of labial cancer operated on in the Surgical Clinic at Göttingen, finds it nineteen times more frequent on the lower than on the upper lip. Women are twelve times less often affected, yet out of three cancers of the upper lip one will be a woman. Sixty years is the average age. No particular cause. If the growth be as big as a hazel-nut the glands may be involved, and small, unimportant glands be carcinus. The jaw-bone may be affected after three months' duration; in nine months it is quite frequently attacked. A transition to the maxillary bone excludes definite recovery. A radical operation is very dangerous. If the lymph-glands be affected the prognosis is much more gloomy. Extirpate all glands which may be palpable. Extensive operative measures on the maxillary bones are very serious and best left undone. Of those operated, 6.5 per cent. died from the operation; 32.5 per cent. recurred. —*Muenchener Medicinische Wochenschrift*, No. 6, 1899.

Frank H. Pritchard, M.D.

SALICYLIC ACID SALVE IN ACUTE ARTICULAR RHEUMATISM.—Dr. Siwierzew in several cases used the following unguent, with good results: Salicylic acid, oil turpentine, āā 10.0; lanolin, āā 10.0; lard, 80.–90.0. In the acute stage it was only applied on a cloth; later, two to three times a day rubbed in for three to five minutes. By uranalysis he has ascertained that the acid is rapidly absorbed in large quantities by the normal skin. His results were very favorable; the painfulness and swelling of the joints quickly decreased, and the temperature sank. The most important feature was that the patients who were decidedly sensitive to the drug internally tolerated the salve well, and even after a long use did not exhibit any disturbances of the gastro-intestinal tract, nervous system or heart. No recurrences nor transition to the chronic form were noted. —*Wiener Medicinische Presse*, No. 6, 1899.

Frank H. Pritchard, M.D.

BISULPHATE OF SODA AS AN ANTISEPTIC IN SURGERY.—Dr. R. Friedlaender, of Berlin, employs the bisulphate of soda in 3–5 per cent. solutions as an antiseptic in surgery. He has employed it in two hundred cases, notably in infected ulcers, especially of the legs. He advises a mixture containing 23 gms. 80 cgms. of the bisulphate with 10 gms. 60 cgms. of anhydrous carbonate of soda to neutralize the acid formed by decomposing of the sulphate which liberates oxygen. He has obtained rapid healing in ectropion of the cervix uteri by dusting with a mixture of equal parts of this salt and talc. It is generally well borne, except in children with very tender skins, where it irritates the skin surrounding the wound. It blackens the instruments, unfortunately, and hence cannot be employed during an operation. —*La Semaine Medicale*, No. 6, 1899.

Frank H. Pritchard, M.D.

THE CLINICAL CHARACTERISTICS OF ANEURISMAL PAINS.—Prof. Huchard insists on the clinical value of the pains as a diagnostic factor in deep-seated aneurisms of the chest, particularly of the descending aorta. He observed a man who walked bent over almost double, in order to relieve the intolerable thoracic pains from which he suffered and which were situated behind on the left side, five fingers' breadth from the spinal column, and on a level with the ninth and tenth intercostal spaces. On standing erect the pain increased considerably; on lying down the pains were sharper, and ceased wholly on lying on the face or the left side. There was no pain either spontaneously or on pressure along the intercostal nerves. These signs were not the usual ones of an intercostal neuralgia, which for four years had been the diagnosis and which resisted every antineuralgic measure. The persistence, the violence of the pains had brought about insomnia and a nervous state, whence intercostal neuralgia with neurasthenia had been diagnosed. The clinical peculiarities of these pains, their limited area, their aggravation by change in position (a very important feature), their intractability to medication, and the syphilitic antecedents of the patient led Huchard to suspect aneurism of the descending portion of the thoracic aorta, which he found to be present. There was easily visible and palpable pulsation of the left thoracic wall posteriorly. A diagnosis of aneurism near the origin of the splenic artery was confirmed by radioscopy, and by sphygmographic tracings made near the tumor. The patient's arteries were atheromatous, there was albumin in his urine, and signs of interstitial nephritis, which explained the existing hypertrophy of the left ventricle. High arterial tension from the interstitial nephritis exposes the patient to rapid growth and early rupture of the aneurismal tumor. Therefore, diet is of chief importance. Huchard long ago demonstrated that the toxins of our foods are vaso-constrictive. He would caution against fat soups, meat juice, "high game" and underdone meat, sea fish, preserved meats, cheese, game and spices. Milk diet is useful (exclusive), three to four litres a day, with vegetables, a few eggs, and, above all, grapes, but little or no meat. Tea, coffee, liquors, beer and tobacco are of course prohibited.—*Rivista Critica di Clinica Medica*, No. 8, 1900. Prof. Hayem once observed such a case where the violent pains were limited to the stomach and gave rise to errors of diagnosis.

Frank H. Pritchard, M.D.

TWO CASES OF HEMIPLEGIA OCCURRING DURING AN ATTACK OF SCARLATINA.—Dr. Ferrier, at a recent meeting of the Société Médicale des Hôpitaux of Paris, reported on two cases of hemiplegia complicating scarlatina. The first was affected on the sixth, the second on the seventh day of the disease, with left-sided paralysis, preceded by a "stroke," with fever and incontinence of urine and feces. This hemiplegia was associated, in one patient, with muscular atrophy and exaggeration of the reflexes, and in the other with secondary contractures and epileptoid trepidation. The absence of sensitive and sensorial disturbances, together with the presence of Babinski's sign, led him to regard the condition not as simple disturbances of function, but as due to small areas of softening in the cortex.

In the discussion M. Rendu stated that the hemiplegias sometimes accompanying infectious diseases should be attributed to little areas of sclerosis consecutive to circumscribed arteritis.—*Le Semaine Médicale*, No. 12, 1900.—

(Sharkey, of London, has reported such a case. Strümpell, I think, directed attention to this form of hemiplegia of cortical origin.)

Frank H. Pritchard, M.D.

EXANTHEMS DURING GONORRHOEA.—Dr. Buschke has had opportunity to observe two cases of gonorrhœal exanthem. In the first, after chronic gonorrhœal urethritis, there appeared pain and swelling of various articulations, as well as an endocarditis of the mitral valve, with dilatation of the left ventricle. At the same time an exanthem was noted which closely resembled urticaria in being superficial, yet with infiltration of the deeper layers of the cutis, somewhat analogous to erythema nodosum.

The second patient was a domestic, with acute gonorrhœa of the urethra, cervix and rectum, with a fistula (gonorrhœic). During the acute stage there developed, along with arthritis of the ankle-joints, an eruption of the skin, which simulated erythema nodosum; during the further course of the case pericarditis sicca complicated it. From a study of the literature he groups the gonorrhœal exanthems into four kinds: 1, eruptions resembling scarlatina and measles (erythemata); 2, symptoms like erythema nodosum; 3, hæmorrhagic and pemphiginous eruptions; and, 4, hyperkeratoses (rare).

In general, the eruptions set in quickly, without fever, though this latter may be present, and even high. They may be due to toxines, or even to emboli of micro-organisms in the cutaneous blood-vessels.—*Weekblad Van Het Nederlandsch Tijdschrift Voor Geneeskunde*, No 12, 1900.—(Possibly some of these exanthems might be due to the remedies employed. I have seen a beautiful morbilliform eruption from oil of copaiva.)

Frank H. Pritchard, M.D.

THE PREVENTION OF EPIDEMICS IN SCHOOLS.—Dr. Steinhardt, a specialist in children's diseases and a school physician in Nuremberg, advises in order to hinder the spread of epidemic diseases in schools that the parent inform the principal of the school, in case an epidemic disease attack a child, that the others who have been exposed may be examined early. Diphtheria, measles, scarlatina and whooping-cough are the diseases particularly of which he writes. Convalescents should be kept at home until the disease has run its course; measles require at least three and scarlatina six weeks. Children with whooping cough are liable to infect as long as they cough (?). In diphtheretic patients he does not require a bacteriological examination of the throat on account of the technical difficulties, for, after four weeks of convalescence, these patients practically are not dangerous to their surroundings.—*Weekblad van Het Nederlandsch Tijdschrift Voor Geneeskunde*, No. 16, 1900.

Frank H. Pritchard, M.D.

A NEW REAGENT FOR SUGAR IN THE URINE.—Dr. Edlefsen advises the employment of a 1 per cent. solution of the permanganate of potash, one drop of which is dropped into a very dilute solution of hydrate of soda (five ccms.). A certain number of drops of the suspected urine are added to this reagent, the quantity to vary according to the greater or lesser amount of sugar present in the urine. If it be present it turns black. This is a very sensitive reagent. The oxyhydrate of manganese which is formed, if sugar be present, gives the urine a brownish color, and remains in solution, and the liquid remains limpid, while it forms a brown precipitate under the action of other reducing substances.—*Rivista Critica di Clinica Medica*, No. 15, 1900.

Frank H. Pritchard, M.D.

APPENDICULAR PLEURISY.—Prof. Dieulafoy calls attention to a form of pleurisy which may complicate appendicitis, and which he denominates appendicular pleurisy. Extending by the lymphatics, it gains the peritonæum, extends through the right hypochondrium and invades the right pleural cavity. It usually appears from the eighth to the fifteenth day from the beginning of the appendicitis, and as infection does not commence before the third to the fourth day there is time for the surgeon to intervene, for in suppressing the root of infection the secondary affection is prevented. Any appendicitis, slight, acute or intense, may be complicated by pleuritis. This complication, usually right-sided, is preceded by hepatophrenic symptoms; pains in the right hypochondrium, radiating into the shoulder, dyspnœic anxiety, apparent increase in size of the liver. These are due to a perihepatitis and to a subphrenic empyæma which precede the pleural involvement. These latter appear in their turn; pain in the side and cough and are confounded with those immediately preceding. Appendicular pleurisy does not always follow the same course. Usually it is putrid, with a vast effusion. In the beginning there are more or less pronounced and extensive friction sounds, but quite rapidly the signs of an effusion follow; dulness, absence of vibrations, souffle, etc. The fever is variable; in some cases violent, in others slight. The dyspnœa, anxiety, loss of strength, the bad character of the pulse, the pale and earthy color of the countenance of the skin testify to the gravity of the situation. Pleural as well as peritoneal infection, both are at the bottom. Œdema of the chest-walls is not rare. On percussion at the upper portion of the chest exaggerated tympanism and on auscultation the signs of a pneumothorax are noted; amphoric murmur and hippocratic succussion. The first idea to occur to one is that a tuberculous perforation of the lung has happened, and, indeed, such a condition has long been known to occur in this situation; rarely does one think of a pneumothorax by putrefaction. But whether this be present or not the nature of the exudate should be determined by exploratory puncture, when it will be seen that it is not truly purulent, but dirty, serous, turbid, grayish and fœtid. Without awaiting the results of cultures (aerobic or anaerobic) the empyæma should be operated on immediately. Sometimes the pleural infection is reduced to a minimum, with a slight serous effusion which is easily absorbed. It is not a very common complication.—*La Semaine Médicale*, 15, 1900.

Frank H. Pritchard, M.D.

HYPERTROPHIC BILIARY CIRRHOSIS BEGINNING WITH AN ENLARGEMENT OF THE SPLEEN.—Dr. Milian, of Paris, at a recent meeting of the Société des Hôpitaux reported on a young man of 22 who last October commenced to complain of pain in the left hypochondrium, with alternating diarrhœa and constipation, etc. At this time nothing abnormal except a considerable hypertrophy of the spleen was noted. A short time after slight icterus set in which gradually increased in intensity without the stools being clay-colored. Simultaneously there was considerable augmentation in size of the liver, and the urine yielded Gmelin's test for bile. The blood was examined with negative results, and the patient, who never presented any fever, succumbed in February, after repeated hæmatemeses. The diagnosis had been Hanot's disease, beginning in the spleen.

The necropsy showed that there actually was an hypertrophic biliary cir-

rhosis, without ascites. The hæmatemeses which had caused death were due to a slight ulceration situated in an œsophageal varix. The spleen weighed 1900 gms. and the liver 2070 gms. All the abdominal glands, lymph-glands and those of the hilus of the liver in particular were hypertrophic; the blood was not coagulated in the vessels. Microscopic examination revealed cirrhotic lesions of the spleen, with almost complete disappearance of the glomeruli of Malpighi; the liver presented porto-biliary cirrhosis, with periangiocolitis; the glands were sclerotic and filled with biliary pigment.

In the discussion, Chauffard asserted that the splenic lesion often precedes and dominates the hepatic one. Hayem claimed that he had described this state as chronic splenomegalic icterus.—*La Semaine Médicale*, No. 15, 1900.—(Banti has described an interesting condition with a triple combination of anæmia, enlarged spleen and cirrhotic liver. Some of these cases he thinks represent the terminal stage of a splenic anæmia. There are three varieties of cirrhosis of the liver with which enormous enlargement of the spleen may be associated, and which may lead to doubt in diagnosis: Alcoholic, syphilitic and hypertrophic cirrhosis, with melanoderma, and enlarged spleen and diabetes—diabete bronze. Osler considers these differentially in the January number of the *American Journal of the Medical Sciences*, 1900.)

Frank H. Pritchard, M.D.

TREATMENT OF PULMONARY TUBERCULOSIS BY COLLAPSING THE LUNG (Leach, Columbus, Ohio).—"I can say unhesitatingly that in those cases which I know to be suitable for the treatment, viz.: apical or monolobar tuberculosis, and in it there is a cavity without too many adhesions, it has proven most satisfactory."

The apparatus necessary for the proper injection of the gas consists of a suitable tank for storing the gas, a graduated bottle in which the gas injected may be measured, and a third bottle for securing hydrostatic pressure by means of which the gas may be forced in the pleural cavity.

The patient is placed on a suitable table or couch, and a rigid aseptic technique followed. The trocar is introduced in the fifth or sixth intercostal space slightly back of the anterior axillary line. It requires at least from sixty to eighty cubic inches of nitrogen gas to compress an ordinary case, and as much as two hundred may be required. This is regulated by the symptoms, pain, distress, labored breathing, extreme cyanosis, rapid heart's action, and displacement of the diaphragm. The respiratory sounds on that side should be absolutely suppressed unless some of the symptoms render it necessary to stop short of obtaining that point. After withdrawal of the trocar the wound is sealed with collodion, and a firmly wound roller bandage is placed in the intercostal space over the seat of puncture, and held in place by means of adhesive plaster.

Of the possible accidents that may occur during the operation. First, gas embolism; second, wounding of the intercostal vessels; third, pulmonary hæmorrhage from puncture of the lung tissue; fourth, wounding of the pericardium in the event of its being distended.—*Columbus Med. Journal*.

Herbert P. Leopold, M.D.

THE TREATMENT OF EPILEPSY IN ITS INCIPENCY (Spratling).—The epileptic phenomenon may occur in early life from the following causes:

1. Direct transmission of the epileptic foci from the parents.

2. Accidents at birth.
3. Results of intense pathological processes-rachitic or tuberculous and scrofulous children.
4. Results of indigestion and malassimilation of food.
5. Accidents of early life common to that period.
6. To the grave physiological disturbances that come at puberty.

At the Craig Colony for Epileptics the treatment is divided under three broad heads. First, the medicinal; second, the dietetic; third, the moral.

Care should be used to administer no food that cannot be readily absorbed and assimilated. Great stress is laid upon the systematic exercise of all the muscles of the patient's body. The remarks are summarized as follows:

1. Make an early differentiation of the type of epilepsy.
2. If it be reflex epilepsy the chances for a cure are good.
3. If genuine epilepsy, a more accurate diagnosis can be given, and better principles can be applied in the treatment.
4. Remove, as far as possible, parental sympathy.
5. Endeavor to keep from the patient the many patent nostrums.
6. If the seizures be localized, apply physical means for its correction as soon as possible.
7. Learn to place great value on little things in studying the etiology and treatment of this obstinate malady.—*Buffalo Medical Journal*.

Herbert P. Leopold, M.D.

SOLUBLE PRODUCTS OF THE FUNGUS PARASITE OF HUMAN CANCER AND OF THE NECTRIA DITISSIMA (PARASITE OF CANCER OF TREES); PHYSIOLOGICAL AND THERAPEUTICAL ACTION OF NECTRIANINE.—Bra, of Paris, and Mongour, of Bordeaux, while pursuing their researches regarding the action of soluble products obtained from cultures of the fungus parasite of human cancer, Bra succeeded in isolating and cultivating regularly the nectria ditissima, the parasite of the chancre or cancer of trees.

The process for the extraction of nectrianine, employed by Bra and Chaussé, is as follows: Cultures of two months of age, in grape broth, are evaporated on a water bath until reduced to a third of their original volume. They are then filtered through paper, and again through porcelain. The liquid obtained is then taken to the autoclave at a temperature of 120° C. One is thereby assured that all the spores are killed by sterilization. The nectrianine then appears under the form of a clear liquid having a yellowish-brown hue. Injected into healthy animals by the subcutaneous route in doses repeated several times per week of five c.c. each, no appreciable general phenomena are determined, and no loss of weight. In man and animals with cancerous tumors, on the contrary, the temperature is raised in two, three or four hours from 1 to 3°. If the dose is increased, this hyperthermia is accompanied by chills, a sensation of cold, acceleration of pulse, cardiac palpitations, headache and thirst. The crisis terminates at the end of some hours by polyuria and profound sleep. This reaction may be absent in very advanced cancer.

Nectrianine appears, therefore, to be possessed of vaccinal properties. In fact, animals which have been submitted to repeated injections of this product, and have then been inoculated with cultures, have never developed experimental tumors, and the results have been limited to the formation of abscesses.

The therapeutic action of nectrianine has been studied by Mongour in Hospital St. Andre at Bordeaux, in the service of Dr. Durand. They treated exclusively cancers which were primarily inoperable, or those in which palliative operations had been followed by relapses at a longer or shorter interval.

Despite the slight toxicity of the product employed, which required from thirty to thirty-five grammes per kilos of rabbit to produce a fatal result by intravenous injection, we have never exceeded the maximum of four c.c. injected daily.

The material was divided in the following manner: There were fourteen cases of carcinoma uteri, one of epithelioma of the face, one of carcinoma of the stomach.

After detailed account of the experiments made upon the above cases, they say: "What conclusions may be drawn from these facts? In restricting ourselves rigidly to the modifications presented in the local conditions, we may state with certainty that the nectrianine has produced evident improvement, viz., arrest or diminution of hæmorrhages, suppression of fætid discharges, a tendency at times to epidermization of the neoplasm, with a corresponding well-defined arrest in its evolution. If by the side of these tangible modifications we range the constant aggravations after the treatment was discontinued, and the amelioration which regularly followed the resumption of the injections, we have, perhaps, a right to regard this new *toxine-therapy* as efficacious.—*Medical Review of Reviews*, April, 1900.

W. D. Carter, M.D.

THE ACTION OF THE SUPRARENAL EXTRACT.—In *Merck's Archives* (June, 1900), Somers summarizes his conclusions as follows:

1. The aqueous extract of the suprarenal gland is the most powerful astringent and vasomotor constrictor that we possess.

2. Its action is peripheral, is exerted directly on the vessel walls and basement membrane, and is limited to the parts with which the drug comes in contact.

3. It is non-toxic, non-irritating, cannot produce a vicious habit, and may be repeatedly used on the same individual without losing its power.

4. It prevents to a marked extent the toxic effects of local anæsthetics by retaining them in the tissues and preventing absorption.

5. The aqueous extract readily decomposes on account of the large amount of animal matter present, but the degree of putrefaction in no way impairs the physiological activity.

6. It first blanches and then contracts mucous tissues, and will subdue active or passive inflammation.

7. Its activity is not impaired by boiling, and it may be repeatedly sterilized in this manner, while carbolic acid will preserve the solutions indefinitely and in no way impair their value.

8. It will prevent primary, and greatly lessen the danger of secondary, hæmorrhage.

9. Its action is manifested in 20 seconds, attains its maximum in 5 minutes, and lasts from 1½ to 24 hours.

10. It increases the tonicity of the parts, augments the action of other drugs, especially cocaine, and diminishes post-operative swelling.

11. It markedly restricts exuberant granulation-tissue wherever situated.

12. Finally, it diminishes secretion and aids in more rapid healing.

He recommends the following as a permanent solution which will not decompose or lose its activity for several months :

R Adrenal,	20 grs.
Phenic acid,	2 grs.
Eucaïn B.,	5 grs.
Distilled water,	2 drs.

Macerate 10 minutes ; filter.

This is said to be a valuable local application in hay fever, and is remarkably efficient in controlling bleeding or inflammation and producing anæsthesia of mucous membrane.

F. Mortimer Lawrence, M.D

SANATORIUM TREATMENT OF CONSUMPTION.—Patients in the sanatorium at Sheffield, England, are required to spend a great deal of time in the open air, are given a liberal diet and are encouraged to exercise, while medical treatment is ignored in great measure. The following conclusions are offered : In almost all cases gain in weight has preceded improvement in temperature ; with healing lesions the minimum daily temperature has been at or below 97° ; the amount of sputum steadily diminishes as health improves and increases during relapse ; from May to September patients in all stages, except a few hopeless ones, improved in all respects ; after October the bad cases relapsed, and those not so bad remained stationary or improved but slowly ; of 36 cases treated 18 are at present in-patients, 5 are dead, 1 improves under open-air home treatment, 5 are working and in good health, 3 returned to work and have been lost sight of, and the remaining 4 went home improved, but are now worse. It is useless to admit advanced cases unless a sanatorium be especially suited to them in respect to climate, etc. In those cases with limited lesions, no constitutional disturbances, and unimpaired digestion, the disease in the majority of cases has been arrested, the lungs have progressed well toward healing, and in several patients are apparently completely healed.—*Quarterly Med. Journal*, Feb., 1900.

F. Mortimer Lawrence, M.D.

PROGNOSIS IN HEART DISEASE.—Morrissey, of New York, pleads for a more rational prognosis in cardiac affections. Diagnosis should not be based upon physical signs, but on a consideration of the cardiac efficiency, the presence of hypertrophy and of the condition of organs far removed from the thoracic cavity whose relations, while not intimate, yet are closely affiliated with the results arising from interference with the circulatory system. Obtain an accurate and comprehensive history of the causation. Closely consider any special features of the case. When a heart murmur is discovered, do not give a gloomy prognosis upon that fact alone. Consider the condition of the heart-walls, the probable length of time the lesion has existed, the presence of dilatation or hypertrophy, or both. The occupation and temperament of the patient are very essential factors in the prognosis.

Murmurs do not invariably mean endocarditis, and a prognosis based simply on the presence of a murmur would be rank injustice to a patient, and demonstrate incapacity on the part of the physician. A presystolic murmur does not always indicate a mitral stenosis, nor has a so-called musical apex murmur any particular significance in prognosis, indicating, as it does, the passage of a stream of blood through a small aperture in the segment of a valve. From the standpoint of longevity aortic stenosis is a favorable lesion.—*Phila. Med. Journal*, June 9, 1900.

F. Mortimer Lawrence, M.D.

MALARIA AND THE MOSQUITO.—At the recent meeting of the American Medical Association, a complete abstract of whose proceedings appears in the *Philadelphia Medical Journal* (June 9, 1900), Lazear, of the United States Army, described the microscopic appearances of the tertian, quartan and estivo-autumnal malarial parasites throughout their cycles of development. In the latter type of organism there is a sexual development; the male form is furnished with a flagellum, while the female form is devoid of any such appendage. Observers have seen the male form penetrate the female parasite.

Thayer, of Baltimore, summarized the recent study of the mosquito as the agent in malarial transmission. This work shows that the mosquito is able to remove the parasite from the human body; that the parasites develop by sexual methods in the stomach-wall of this host; that, thence, passing into the venomo-salivary gland, the parasite, in the form of sporozoids, may be inoculated into uninfected individuals and produce the disease. These results have been confirmed by the author and his associates in Baltimore. The parasite undergoes an asexual cycle of development in the human body and a sexual cycle in the body of the mosquito of the genus *Anopheles*. Investigations will finally show that mosquito-bites are the only means of transmission. Investigations seem to show that mosquitoes are always present in a malarial district, or else the cases occurring in such a district are imported. Further, the observations seem to show that the mosquito acquires the parasite only from man. The early spring cases are all relapses, which decrease in number in June, and the new cases begin in July, when the *Anopheles* begin to bite. Prophylaxis requires that patients be isolated under mosquito-netting and that the mosquito larvæ be killed.

F. Mortimer Lawrence, M.D.

TREATMENT OF NEURASTHENIA.—Brower, of Chicago, believes that more advancement has been made along the line of pathology and diagnosis than the therapy of this disease. Neurasthenia is an exhaustion of the neurones, the effect of defective metabolism, a pathological fatigue arising most frequently from gastro-intestinal auto-intoxication. The vasomotor system is first to show the effects. Rest, both mental and physical, is the best treatment, yet he believes that absolute rest is not necessary in many cases. Weir Mitchell's method, with rest, isolation, massage, Faradic electricity and special diet, is effective in severe cases. Partial rest, however, is all the majority require. They should go to bed early, sleep late, and take a rest of one to two hours at noon. The diet should be nitrogenous. The pre-digested foods, preferably malted milk and somatose, are of great value. In absolute-rest cases, general Faradism is necessary, beginning gently at the extremities and extending gradually over the entire body. The partial-rest cases should have static electricity. Hydrotherapy favors elimination and promotes sleep, while massage, given gently at first, is very beneficial. Toward recovery, light exercise should be undertaken, but care should be exercised not to overtax the body.—*Phila. Med. Journal*, June 9, 1900.

F. Mortimer Lawrence, M.D.

THE DIAGNOSIS OF CHOREA.—According to Eshner, of Philadelphia, there appears to be some ætiologic relationship between chorea and articular rheumatism. They are both, probably, acute infectious diseases. Chorea is a self-limited disease, and the choreic movements are peculiar and distinctive.

The disorder should be differentiated from so-called habit chorea or habit-spasm or spasmodic tic, from so-called chronic or senile chorea, and from in-co-ordinate movements of hysteric origin.—*Phila. Med. Journal*, June 9, 1900.

F. Mortimer Lawrence, M.D.

COMPLETE EXTERNAL DISLOCATION AT THE ELBOW.—Winslow (Baltimore) reports a unique case. The patient, a man of sixty-three, sustained an injury to his right elbow by falling from a wagon. Four days later he was seen by the writer, and an attempt made to reduce an outward dislocation of the elbow under an anæsthetic, but without success. A radiograph showed the following conditions: an absolute displacement of both bones of the forearm to the outer side, the radius was slightly anterior to the ulna, and the inner side of the coronoid process of the ulna was placed in front of and just below the external condyle of the humerus, whilst the olecranon process was behind and above the condyle. There was a slight amount of flexion and extension—passively, and the forearm was fixed in pronation.

The luxation could not be reduced, and an operation was undertaken. It was then found that the main obstacle to replacement was the tendon of the triceps, which was displaced to the outer side, and attached normally to the olecranon process. This was cut quite across, when the bones were made to resume their natural relations. Four weeks later the wounds had healed, with the arm in a useful position, and a certain amount of passive, but no active, motion. The functions of pronation and supination were unimpaired.—*Annals of Surgery*, May, 1900.

Gustave A. Van Lennep, M.D.

CARBOLIC GANGRENE.—Harrington (Boston) has collected personally eighteen cases of gangrene of the extremities, produced by the application, for a number of hours, of a dilute solution of carbolic acid. In a large proportion of these cases amputation was necessary. The history of the reported cases varies but little. In all of them the acid had been applied in the form of a moist dressing, and the part kept saturated with the drug for a number of hours. It was impossible to determine the exact strength of the solution used, as the treatment was, in the majority of the cases, undertaken by the patients themselves for the relief of cuts, bruises or felons. It is safe to say, however, that it was not stronger than a 5 per cent. solution, since water, which is the common solvent, will not take up more than 5 per cent. of the acid. It is interesting to note in this connection that Péraire's case, a child of 10 years, lost the second and third joints of the finger after twenty-four's' exposure to a compress saturated with a 1 per cent. solution. Carbolic acid, therefore, between 1 and 5 cent. solution applied to the extremities, is dangerous and its use should be discarded. That gangrene does not always follow, is only another reason why it is so dangerous, for it leads to indiscriminate application to individuals regardless of their physical condition. The result depends on the strength of the carbolic solution, the manner of application, the length of time of application, and the power of resistance of the individual.

Superficial gangrene may follow the application of a solution upon the trunk, but the result is not so disastrous because of the greater thickness of tissues, and because the blood-supply cannot be shut off as it is in an extremity. In the latter instance the gangrene is not from compression, but simply from

the action of the carbolic acid. The author believes that "carbolic acid of any strength should be included in the list of those drugs which can only be procured by a physician's prescription. Whatever the strength, it should always be labelled as dangerous."—*American Journal of the Medical Sciences*, July, 1900.

Gustave A. Van Lennep, M.D.

BACTERIOLOGIC AND CLINICAL RESEARCHES WITH REFERENCE TO SLIGHT ELEVATIONS OF TEMPERATURE DURING THE PUERPERIUM.—Dr. K. Franz Halle, after most extensive observations makes the following summary:

1. Slight elevations of temperature during the puerperium are usually caused by saprophytes which gain access to the uterine cavity.
2. The saprophytes themselves do not cause fever. It develops only when the outflow of the bacteria-containing secretion is prevented.
3. The saprophytes which are found in the uterus in cases of slight elevation of temperature are probably identical with the saprophytes of the vagina.
4. Internal examination is usually a factor in causing slight elevations of temperature, only in so far as it causes vaginal wounds which serve to further the development of the bacteria which are always present.
5. Slight elevations of temperature occur oftener by half in primiparæ than multiparæ.
6. Diminishing the duration of the third stage increases the number of slight elevations of temperature.
7. Long duration of labor, long duration of the expulsive stage, and premature rupture of the membranes, have but little influence in the production of these cases.—*Obstetrics*, May, 1900.

W. D. Carter, M.D.

MALARIA AND CHILDBED.—Dr. Manuelides, of Constantinople, in a paper read before the Imperial Society of Medicine of that city, in a study of the relations of paludism and the puerperium, states that:

1. Labor being in itself a traumatism, it may awaken dormant malaria in the system, acting like any accidental trauma, or as an operation.
2. The attack may follow immediately or on the second or third day; thus puerperal fever may be simulated. Quinine and the intermittent course of the fever will facilitate diagnosis. Paludism does not predispose to puerperal infection. If they be associated the prognosis is not rendered more serious.—*La Grece Medicale*, No. 2, 1900. (Auvard, *Tratado Practico Departos*, p. 433, asserts that a chill, followed by fever during the puerperium, should lead one to think of malaria *if septicaemia may be excluded*. The action of quinine in pregnant women is seemingly concentrated on the disease itself, so that often it does not act as an oxytocic. This drug in nursing females may be excreted through the milk, and give rise to serious symptoms of poisoning in the child. The child should not be allowed to nurse for three hours after it is administered, and the breasts milked out that that milk containing the drug be not taken by the child.

Frank H. Pritchard, M.D.

THE CONSERVATIVE TREATMENT OF INFLAMMATORY DISEASES OF THE UTERINE APPENDAGES. (Herrmann.)—In 1005 cases, the pus in the tubes was sterile in 578; in 216 cases there were gonococci; in 118 there were streptococci, or staphylococci, and in 93 cases various other germs. The

gonococcus extends up to the tube by spreading along the mucous membrane, and only then secondarily plays a part in inflammation of the peritonæum. The strepto- and staphylococcus, on the contrary, find their way through the lymphatics and blood-vessels, and more often cause fresh or acute infection. This is seen in puerperal sepsis, and in these cases the excessive tubal distention characteristic of gonorrhœa is not present.

Martin believes that all forms of acute salpingitis may heal, so as to offer no obstruction to conception. He has seen even chronic purulent sacro-salpinx heal without occlusion of the ostium abdominale, and has observed three pregnancies follow. Acute gonorrhœal salpingitis always involves the peritonæum, but it may also heal, and he has seen pregnancy follow in two cases.

Küstner emphasizes the conservative position he had already taken. The gonorrhœal processes can very often be cured, even when the tubes are markedly distended, so as to form distinct so-called "exudations" in the pelvis.

Isaac warns against active interference, as, in spite of apparently threatening conditions, he has seen every symptom disappear in consequence of conservative treatment, even in severe chronic cases, and pregnancy afterwards was not unusual. Other distinguished writers express similar opinions. In a general way it may be said that:

1. A certain per cent. of cases may recover without operation and retain their functions.

2. Healing and retention of function is possible, even when the collection of pus is considerable.

3. In adnexa disease, requiring an operation, the portion left behind may not be seriously affected and regain its normal function.

In a general way the principles of treatment can be summed up as follows:

1. Resorptive-antiphlogistic treatment should be persisted with as long as possible in acute cases, in view of the possibility of a spontaneous cure.

2. Operate in chronic cases when the sterility of the pus can be counted on, *i.e.*, nine to twelve months after the termination of infection.

3. Open the abdominal cavity by laparotomy. It admits exactness, sight, and is less dangerous.

4. Use the greatest degree of conservatism with a view to the restoration of functions.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. xlii., H. 2, 1900.

George R. Southwick, M.D.

OCCIPITO-POSTERIOR POSITIONS OF THE VERTEX. (Bollenhagen).—Premature rupture of the membrane is to be avoided, unless a considerable period of time has elapsed, when rupture is necessary to allow the configuration of the presenting head. Manual correction of the position is not to be recommended. Never apply forceps to the occipito-posterior position if it can be avoided, and then in advanced labor. Never apply the forceps if the head has not entered the brim of the pelvis. Veit recommends prophylactic version if the os is not fully dilated, and urges the greatest care, if labor has progressed further, against stretching the posterior wall of the lower segment of the uterus. Motta advises against prophylactic version, as the immediate extraction is impracticable, and version later in labor, even twenty-five hours after rupture of the membranes, has given good results. The great importance of patient waiting is particularly emphasized.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. xlii., H. 2, 1900.

George R. Southwick, M.D.

ON THE INFLUENCE OF VIBRATORY MASSAGE IN OPHTHALMIC THERAPY.—Epiniatjeff as well as Snegirew worked with the vibrator of Maklakoff. They found that massage increases diffusion into the anterior chambers, hastens absorption of pathologic products out of it, lowers the intraocular tension, aids in the removal of opacities of the cornea (unless, however, in old leucoma), acts well in parenchymatous inflammations and pannus when all signs of inflammation are absent. Whether massage is of any good in episcleritis is doubtful, but it is useful for neuralgia of the supra- and infra-orbital nerves and paralysis of the ocular muscles; it also helps the absorption of inflammatory infiltration of conjunctiva, skin and tarsus of the lids.—*Thesis, St. Petersburg.*

Wm. Spencer, M.D.

AMBLYOPIA NICOTINICA.—Lopez, of Havana, Cuba, reports a case of tobacco amblyopia, of interest because of its rarity, and that, too, in a tobacco-raising and consuming country. He at one time even doubted the existence of the pure tobacco form, but is now convinced by his own experience. The patient, 40 years old, of good physique, smoked two packages of cigarettes (probably 40 to 50) a day, and drank coffee, but no alcohol except a glass of wine at each meal. He at first complained of headaches, but afterwards his vision grew worse. There were some signs of atrophy. After abstinence from both coffee and tobacco, vision returned to normal in the right eye, and to two-thirds in the left. The reporter does not think the coffee is any to blame.—*Annals de Ophthalmologia.*

Wm. Spencer, M.D.

DIABETIC LARYNGITIS.—Patients whose urine contains an appreciable amount of sugar, but whose general health has not yet suffered, will often consult the physician for a peculiar dryness of the throat and insufficiency of voice after use. On examination the posterior pharyngeal wall is found to be dry, smooth, glistening, and copper-colored, and the vocal bands have a peculiar shiny, glazed appearance. O. Leichtenstern considers these signs as diagnostic of early diabetes.

With proper dieting, the part will return to the normal, showing that there is merely a hypersecretion, without pathological change, although the latter may develop in the form of a sclerosis when the diabetes persists.—*Medical News.*

William Spencer, M.D.

THE USE OF LARGIN IN THE EYE.—The application of largin, even in concentrated form, is painless, but when prolonged beyond a few weeks, may stain the conjunctiva. It acts well in blepharo-conjunctivitis, and in some cases of dacryo-cystitis. It is an efficient substitute for silver nitrates in any of the conjunctiva inflammations associated with the Koch-Weeks bacillus, such as acute ophthalmia and acute or subacute trachoma. It acts admirably as a temporary remedy after any of the operations commonly practiced for the relief of chronic trachoma. In gonorrhoeal ophthalmia, on the contrary, it is distinctly inferior both to protargol and to silver nitrate.

In diplo-bacillary conjunctivitis, too, it does not succeed so well as zinc sulphate. In short, largin seems likely to gain a permanent place among the somewhat restricted number of remedies employed in every day eye-work.—Sydney Stephenson, M.B., F.R.C.S., Edin.—*British Medical Journal.*

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CANTHARIDES AS A HÆMOSTATIC IN HÆMATURIA.—Dr. O. Bevan recommends this drug in hæmaturia, based on the following case. A man of 68, who, formerly healthy until a year ago, then suddenly passed, without pain, quite a quantity of blood in his urine. By rest in bed and under ergotin it disappeared, but as soon as he got up it reappeared. No disease of the urogenital tract could be detected nor were there any pains. During the next ten months all the usual hæmostatics were tried without result. The hæmorrhage increased and the patient became worse and worse, both mentally and bodily. He then was given tinct. cantharides, ten drops three times a day. In twenty-five hours the hæmaturia had wholly vanished and the urine was entirely clear. As the drug was discontinued in ten days the urine became bloody again. This soon cleared up after another dose. For the sake of precaution he directed a dose to be taken now and then. No recurrence has since been noticed.—*Wiener Medizinische Presse*, No. 9, 1899.

Frank H. Pritchard, M.D.

THE POTASH SALTS IN URINARY DISEASES.—According to Cowperthwaite, of Chicago, all the potash salts act upon the kidneys, and to a greater or lesser extent increase the amount of urine and its solid constituents. However, their clinical application in urinary diseases is almost exclusively directed to diseases of bladder and urethra, though kali bromatum has been found useful in diabetes, but more especially where nervous symptoms, characteristic of the bromide, were present. Kali bichromate has been found somewhat useful in nephritis, as is the case also with kali carbonate, kali chlorate, kali iodide and kali nitrate.—*Minn. Hom. Mag.*, June, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF EPIDEMIC INFLUENZA.—Horning, of Minneapolis, considers that in the treatment of this disease the first essential to a rapid and complete recovery, and the one most difficult to obtain, is absolute rest in bed until the system has regained sufficient strength to endure the excitation of physical or mental effort. The patients are slow to believe the deep systemic effect of an attack so apparently trivial. The initial fever, headache and rheumatic pains find almost a specific in gelsemium and eupatorium, an occasional case responding to aconite, ferrum phos. or bryonia. This latter remedy has done better service when the fever has assumed the intermittent type, with afternoon or evening aggravation. The catarrhal conditions of the upper respiratory tract will yield to arum, arsenic, sanguinaria, causticum, phosphorus, arsen. iod., kali bich., or pulsatilla. The neuralgia or rheumatism of the late stage are well met by cimicifuga, arsenic, magn. phos. or china, while strychn., phos. or chin. arsen. materially benefit the general exhaustion.—*Minn. Hom. Mag.*, June, 1900.

F. Mortimer Lawrence, M.D.

CARBOLIC ACID IN SCARLATINA.—Fisher states that carbolic acid has rendered him excellent service in profound blood-poisoning types, with impending or confirmed coma, intense fetor oris, general besottedness of the countenance, patient difficult to arouse, otorrhœa profuse and offensive, glandular involvement destructive. His attention was first called to the wide range of applicability of carbolic acid in the fourth aqueous dilution, by an article from the pen of the late Dr. James Kitchen, of Philadelphia, which appeared in one of the journals about ten years ago, since which time he has often found it valuable. It corresponds to the putrid state of typhoid fever, the blood disorganization of yellow fever, etc. Its pathogenesis presents great prostration, unconsciousness; the heart seems almost to stop beating; disorganization of the blood; dark, almost black, and exceedingly offensive urine; face pale; mouth covered with false membrane; mucous membrane livid, corroded, exuding bloody mucus; throat red and covered with mucus exudation; skin livid, with general chilliness and coldness of the surface of the body. Surely here is presented a characteristic combination of many symptoms of the adynamic state of scarlatina malignosa.—*Med. Century*, May 1, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF CAISSON DISEASE.—Biggar, of Cleveland, in the course of a very complete discussion of this result of abnormal air pressure, states that the method of treatment pursued in the Huron Street Hospital is as follows:

Upon admission the patient is given a hot tub-bath, the temperature of which is increased to the point of endurance. This is stoutly resisted by the patient, because of the excruciating pain caused by movement of any part of the body. He is then given one drachm of aromatic spirits of ammonia in two or three ounces of water, which, in rare cases, may be repeated in two or three hours. Strychnia may be administered hypodermically if indicated. When giving the bath it is necessary to observe carefully the condition of the bladder, as it is frequently found to be greatly distended, and on passing the catheter an enormous quantity of urine may be voided. Cystic paralysis may last for some time and should be carefully noted. The relief following the use of the catheter is surprising.

After the patient is comfortable in bed sufficient morphine is given to keep him quiet, followed by the indicated remedy, which may be arnica, rhus tox., bryonia, nux vomica, belladonna, apis, aconite or secale. The diet should be light in the beginning and gradually increased.—*Med. Century*, July 1, 1900.

F. Mortimer Lawrence, M.D.

THE THERAPEUTICS OF SCLEROSIS.—Brady, of St. Louis, recalls the fact that Dr. Joussett, the famous French homœopath and teacher, discussing the subject of posterior sclerosis and hæmorrhoids, says: "If we continue this analysis of the hæmorrhoidal constitutions, we find the nervous systems so affected as to cause vertigo, neuralgia, headaches, hypochondria, and, above all, the sclerosis of the nervous tissue. It is the hæmorrhoidal subjects who furnish nearly all the cases of general paralysis, of the insane and of locomotor ataxia." This is a hint of great value to both the surgeon and the physician.

Raue, the pupil of Hering, recommends for multiple sclerosis, arg. nit.,

nux vom., phos., physostigma, plumbum and tarant. For locomotor ataxia he recommends alumina met., arg. nit., arsenic, bell., calcarea, cuprum, gelsemium, nux vom., phos., physostigma, picric acid, secale, stramon., sulphur and tarant. Hering speaks of silica as a very valuable remedy in locomotor ataxia. Dr. T. F. Allen has lately called the attention of the profession to the iodide of lead in sclerosis, especially for the sharp, lightning-like pains in the first stage, on which it is said to act like magic. Gelsemium and belladonna are other remedies which are of great value during the same period. Baryta carb. is a remedy to which he desires to call the attention of the profession in all kinds of sclerosis, but especially in multiple sclerosis. The biochemists, or Schuesslerites, speak very highly of kali phos. in posterior spinal sclerosis. The late Dr. Farrington calls attention to the following remedies in the treatment of posterior spinal sclerosis, viz. : Alumina, arg. nit., æsculus hippocastanum (in the use of this last remedy he seems to have apprehended the connection between the hæmorrhoidal diatheses and the production of sclerosis pointed out by Dr. Joussett), causticum, kali bromatum, nux vomica, phos., picric acid, stramonium and zincum. He also calls attention to the use of baryta carb. in multiple sclerosis.—(*Clinical Reporter*, June, 1900.)

F. Mortimer Lawrence, M.D.

THE TREATMENT OF CHRONIC INTERSTITIAL NEPHRITIS.—In the early stages of contracted kidney Blackley, of London, places most reliance upon plumbum, because of its well-known ability to produce that condition. "The urine contains albumin and bile pigment, excretion of urea is lowered to 17 grammes per diem : the uric acid, on the contrary, is increased, probably from increased formation. Under the influence of the poison the nuclein-containing bodies are decomposed in increased quantity, and there appears to be at the same time a decreased power of oxidation, and uric acid is the result. The temporary deposition of such large quantities of uric acid in the kidney easily explains the onset of nephritic symptoms. It leads ultimately to genuine cirrhotic kidney with all its dependent symptoms." The post-mortem examination shows the typical contracted kidney. Charcot, Gombault, Cornil and Brault, by poisoning guinea pigs with white lead, found the glandular element to be the first affected, and upon this depended the ulterior modifications of the connective tissue of the kidney. The changes are by lobules, only certain lobules or even parts of lobules being affected.

The writer has evidently little knowledge of the value of gold ; in the one case in which he gave chloride of gold and sodium it produced gastralgia, and was discontinued.

Where cardiac hypertrophy is present with high tension, and headaches or visual disturbances, glonoin or the alkaline nitrites are called for. Where cardiac dilatation is present recourse must be had to such cardiac tonics as digitalis, strophanthus, strychnine, caffein or apocynum ; and where acute uræmia is threatening pilocarpin is recommended. For the epileptiform attacks of acute uræmia nothing has answered Dr. Blackley so well as cicuta virosa and cœnanthe crocata, and after them bufo.—(*Journ. of the Brit. Hom. Society*, April, 1900.)

(It is evident that this writer has no knowledge of the great value of cuprum arsenicosum in uræmic convulsions, as well as its striking diuretic effects in parenchymatous nephritis.—Ed.)

F. Mortimer Lawrence, M.D.

CLINICAL EXPERIENCE WITH WYETHIA.—Schott, of St. Louis, states that his experience with this remedy, while covering a period of six years, is limited entirely to its effects upon the nasal and bronchial mucus surfaces. He has had excellent results in hay fever, coryza and chronic cough. He relates a number of cases of this character in which wyethia was given with good results, and suggests the need of a good proving of this almost unknown remedy. He urges its trial in cases of hay fever, in which there is a crawling, prickling sensation, with a sense of dryness.—*Clinical Reporter*, June, 1900.
F. Mortimer Lawrence, M.D.

THE FEVER OF ACONITE.—The fever of aconite is strictly sthenic, of the simple continued type, with a total absence* of malignity, tissue changes, periodicity, complications and sequellæ; sometimes having a very mild course and ephemeral existence of from twenty-four to forty-eight hours. These ephemeral attacks of erethistic fevers are frequently met with in nervous children, or occur after the introduction of bougies (urethral fever). Aconite is also often indicated in traumatic or surgical fever, but it is contra-indicated in all fevers depending on a poisoned state of the blood (typhus, typhoid, intermittent, etc.), and in those which bring out eruptions it exerts its remedial influence only when attended by dryness of the skin and anxious agitation.—Fornias in *N. A. J. of Hom.*, June, 1900.
F. Mortimer Lawrence, M.D.

IODIDE OF POTASSIUM IN ACNE.—The *Monthly Homœopathic Review* (June 2, 1900) calls attention to an interesting article appearing in the May number of the *Practitioner*, by Dr. James Galloway, assistant physician and physician in charge of the department for skin diseases, Charing Cross Hospital. He recalls the characteristic pustular eruption produced as the result of the internal administration of iodine. Ringer has stated that this rash does not always present the same appearance; it is often very much like acne, and is always hard, shotty, and indurated. This is corroborated in our provings.

Dr. Galloway goes on to record the case of a young man who was treated with the usual external applications, including a paste containing sulphur and resorcin. He improved, but during the absence of the physician in charge the treatment was altered, and the patient, anxious to have a hand in his own cure, purchased a well-known "blood mixture," containing about 5 grains to the ounce of potassium iodide. A violent iodide eruption ensued, then gradually died away. Some months elapsed before some of the indurated nodules flattened down and vanished. The face remained mottled with irregular pigmented spots till recently, but is now assuming a normal complexion. But the important point of the case is that there has been no recurrence of the acne vulgaris.

It is interesting to note that Leviseur (*Med. Record*, Nov. 11, 1899) recommends iodide of potassium as a means of treatment, especially in the chronic forms of indurated acne, in which comedones are nearly always present. He advises 5 grains of the iodide to be taken in milk three times daily, to be discontinued directly the local reaction occurs or iodine is found in the urine.

As to the untoward effects, which Dr. Galloway says it is necessary to warn the patient of, the *Review* suggests that such warnings would be unnecessary if he would reduce the dose within the limit of the physiological action, and so obtain the full benefit of the therapeutic effect.

F. Mortimer Lawrence, M.D.

THE HAHNEMANNIAN MONTHLY.

SEPTEMBER, 1900.

A CASE OF CONGENITAL DEFORMITY OF THE FEET. OPERATION TO FACILITATE THE ADAPTATION OF ARTIFICIAL LIMBS.

BY HORACE PACKARD, M.D., BOSTON.

(Read before the Surgical and Gynecological Association of the Amer. Inst. of Homœopathy.)

MRS. D., the mother of three healthy well-formed children, gave birth in 1896 to a lusty male child, strong and vigorous in every way, except that both feet were extraordinarily defective, and the right hand was minus one finger.

The case was first brought to my attention in January, 1900, by Dr. Charles L. Woods, of Lowell, Mass. Inspection of the feet showed a totally unclassifiable congenital deformity. No term in our surgical literature is applicable to it. Extreme talipes equinus most nearly describes it, but yet inadequately, as will be appreciated by a study of the accompanying skiagraph and photographs.

In both feet the os calces were turned upward and lay flat along the posterior surface of the lower part of the tibia. In the right leg, the lower inch or two of the tibia curved backward and slightly inward, and on its convexity the integument was slightly dimpled. This foot bore but three toes, two of which were webbed, and these with the corresponding metatarsal bones turned backward, and on the prominence corresponding to the instep was an area of callus. The left foot bore but two toes, and these were almost at right angles with each other, and were attached to an apology of a metatarsus,

which seemed to consist of but little other than soft tissues, for under manipulation it worked easily in any direction, but, unrestrained turned outward. No fibula was discernible in either leg. Even with all this disability, the child could stand alone and walk a few steps, but invariably would quickly drop to the knees. The right foot was doubled so far back, that in standing he rested upon the dorsum, which accounted for the callus before mentioned. The plantar surface of each foot was provided with the ordinary thick dense area of skin, and in his efforts to walk the anterior part of that of the left foot received the impact of each step.

X-Ray Study.—In this instance the X-ray exposure was very unsatisfactory except that it emphasized the great defectiveness of the osseous structures of the feet.

In the right foot it showed three digits with their metatarsals, absence of tarsals except an os calcis; the left showed a still more defective structure. The larger of the two toes looked as if it might be the great toe; the smaller, had no marks of recognition, but showed an attempt at duplication, in an extra centre of ossification at its extremity.

These two toes joined a single, short, thick metatarsal, which looked as though it might be a consolidation of all the metatarsals or an unusually thick one of the great toe. No tarsals except an os calcis were exhibited. The tibiæ are thick and strong, but the fibulæ are entirely wanting.

The malformation of the right hand, although of no interest from a surgical standpoint, is worthy of more than passing interest as an example of adactylia, micro-dactylia and macro-dactylia, *i.e.*, one finger being wholly wanting, the middle of the three fingers present, abnormally small and without a corresponding metacarpal bone, and the first finger unusually large, thick and strong.

An X-ray study of the hand showed but a trace of a metacarpal bone, not more than a quarter of an inch in length, belonging with the dwarfed middle finger and beginning ossification of its diaphesis plainly showed, as should be expected at the present age of the child, three years.

There are but three metacarpals to articulate with the carpus, that of the thumb and of two of the fingers. The carpus is not yet ossified sufficiently to show definitely its arrangement. The

ossific centres of the os magnum and unciform are plainly visible, while a small beginning of ossification of what is probably



to be the cuniform, distinctly shows in its normal relation, *i.e.*, above and to the ulnar side of the unciform. A centre of ossi-



fication appears also at the site of the trapezium, but according to Gray, this should not show until the fifth year. Can we de-

termine from the relation of the metacarpals, to the carpals, what the identity is of the fingers? The giant finger, which is the first or fore-finger in this case, articulates, or evidently will articulate, with both the trepizoid and os magnum. It thus occupies and fills the space of both the fore and middle fingers.



Its large size also suggests that it is some kind of congenital consolidation of these two fingers. The identity of the dwarfed finger is impossible to establish since it is sandwiched in without a metacarpal, between two well-developed digits. The remaining finger articulates with the unciform which identifies it

as the ring finger. Apparently the little finger is wholly lacking. As a whole the hand is very strong and will apparently be a serviceable member.

Maternal Impressions.—The history of this case is not com-



plete without reference to the mental state of the mother during gestation. Nothing herewith stated is to my mind conclusive evidence that the maternal impressions had anything to do with the deformities, for the mother prior to delivery had no thought or anxiety about any possible malformation. She had no reason

to be disturbed, for she had already borne two perfectly formed children. After the child was born and it was made known to



her that it was defective, she recalled that, during the first month of her pregnancy, on a visit to a part of the country

distant from her home, she came in contact with, and saw repeatedly, a child with *one* club foot. She also knew of an operation performed upon it about that time, and felt much pity, but no thought that her own child might be similarly affected. At about the same time she called upon a person in the neighborhood who had suffered for nine years with chronic rheumatism which had resulted in great distortion of the hands. She shook hands with her and noticed the disfigurement of the right hand as she took it in hers. This also aroused her pity and compassion, but still there was no shadow of anxiety for her own offspring.

To me this is not a very strong argument in this case in favor of maternal impressions as a cause of the deformities.

As far as I can learn, the club foot case which she saw was a common talipes varus, of one foot only, while her own child was born with the most defective feet imaginable, not only deformed, but important parts wholly absent.

The case of rheumatic dactylitis which she saw and shook hands with, was an instance of acquired deformity, *i. e.*, all the parts were there, but disease had disfigured them. In her child important parts of *one* hand are wanting; the other hand is normal.

Suppose we accept this theory of maternal impressions and apply it to this case. We are at once confronted by a contradiction. The mother saw a case of single club foot and was "impressed"; therefore her child's feet should be deformed and were, but they were also extremely defective. She subsequently saw a case of disfigured hands and was "impressed;" therefore her child's hands should be disfigured, but they were not, only one hand being defective, the other perfect. This is a digression, however, which I did not intend making, and I am fully aware no argument will settle it. It furnishes an interesting subject for speculation.

Problem Presented.—What could be done to improve the condition of this pitiable cripple? At least he was seriously handicapped in the struggle of life, unless as a freak he might furnish spectacular food for the gaping curiosity of dime museums. The feet as they existed were practically useless.

Should an attempt be made by orthopedic surgery and appliances to restore the defective feet so that he would get a plantar bearing?

Should a partial amputation be made, leaving the os calcis and preserving the plantar integument so as to make an end-bearing stump?

Should the feet be amputated at the ankle-joint and artificial feet be adapted?

On consultation with my associates in the Massachusetts Homœopathic Hospital, the first proposition seemed impracticable on account of the very defective condition of osseous structures of the feet, as well as the apparently utter hopelessness of restoring the os calcis to their normal position by any possible tenotomy or plastic operation. With this proposition disposed of, the prosthenics of the case came up for consideration. Mr. A. Marks, of wooden-leg fame, was consulted, who coincided with my associates and myself that the second proposition was the one to act upon at this period of the child's life, because it would furnish end-bearing stumps upon which the child could walk better than at present without artificial feet, and upon which artificial feet could be adapted as well or better than if amputation were made at the ankle-joint.

It was also a conservative course to pursue, leaving opportunity to reshape the stumps by making further amputation at any subsequent time, if such should be deemed for the patient's best good.

It is difficult to describe just what was done in the way of operation, except to state that a piece was cut away from the anterior portion of each foot, and a flap preserved consisting of thick plantar integument. If there were any tarsus present, I should say that the amputation was made at the tarso-metatarsal articulation. In general terms, the result was a fairly well rounded terminal for each leg, without much interruption in alignment at the ankle anteriorly, but a slight projection posteriorly consisting of the retracted os calcis. The wounds healed kindly, and in a few weeks he was again creeping and struggling about, part of the time on his knees, and part on the stumps.

Casts were made of the legs and sent to Marks for the construction of artificial feet. These were cleverly adapted, and he is at the present writing, five months from the time he came first under my observation, walking about upon serviceable feet.

PROGNOSIS AND TREATMENT OF SYPHILIS.

BY BUKE G. CARLETON, M.D., NEW YORK CITY.

(Presented at the American Institute of Homœopathy, Washington, D. C., June 24, 1900.)

IN the few moments allotted this section, we can only attempt to outline the prognosis and treatment of this chronic contagious disease.

Prognosis.—If the case is seen early, proper treatment advised and correctly and conscientiously pursued by the patient, the various manifestations of the disease are generally easily controlled, giving great satisfaction to both the patient and the physician ; in other words, 97 per cent. of those infected, should recover with but little impairment of life's general usefulness, and with nothing to inhibit them becoming parents of healthy children. The later the case with developed constitutional manifestations comes under proper treatment, the more the prognosis should be guarded. In the later sequelæ or tertiary period, and in hereditary manifestations, while the remedies of traditional medicine, which are ours by common inheritance, will remove gummatous growths, unless the damage to the tissues caused by the meddlesome new growths and their interference in the vascular and lymphatic circulation is properly individualized and treated on the lines of *similia similibus curantur*, a very large percentage will carry the scars of the ravages of the disease until the vital cord is broken, and they pass over to the great majority.

The original lesion usually heals kindly, though often it becomes transformed into a mucous patch or an infecting ulcer, only to disappear, when properly directed constitutional treatment is instituted.

Of the constitutional lesions, those located on the cutaneous and mucous surfaces are the earliest. Without treatment they are troublesome ; with proper care, they respond quickly to correct methods.

Later or tertiary sequelæ conditions rarely appear in well-conducted cases, though it must be acknowledged that the so-

called tertiary manifestations are sometimes the first to appear, constituting what is called malignant syphilis.

The severity of the disease bears no relation to the degree of the primary involvement, but when syphilis is treated by appropriate methods, late secondary and tertiary manifestations are rare. There are, however, individuals, who, after being inoculated, even without treatment, escape with few or no symptoms, owing to a special body resistance or want of vulnerability of their systems to the disease. Hence, from no one special line of treatment, except when a very large number of cases are treated and carefully observed, can proper deductions be drawn as to its success or failure.

As syphilis has a rather definite stated time for its duration, and the manifestations of some of the special lesions may be trivial or severe, the disappearance of this or that particular set of symptoms in a few cases, does not prove that the method of treatment employed is especially to be commended.

In hereditary syphilis, Fournier estimates that the paternal impression is transmitted in 37 per cent. and results in the death of 28 per cent.; that the maternal impression is transmitted in 84 per cent. and results in the death of 60 per cent.; when both parents are infected, 68½ per cent. die and 92 per cent. present evidences of syphilis. If proper treatment is given during gestation to the syphilitic mother, a very large percentage of the infants born to her may come into the world free from specific manifestations, and remain so. If, however, the infected father, before the next conception, or the mother during the next period of gestation, is not placed under appropriate treatment, the offspring will often be syphilitic. Cases of twins have been reported where one was diseased and the other healthy.

Congenital syphilis presents a very unfavorable prognosis, though it will be modified by the degree that the methods of traditional medicine are reinforced by the indicated remedy to relieve the defects.

It is considered advisable to keep a patient with acquired syphilis under observation for about three or four years. The female should not, as a rule, be discharged until the end of the fourth year. She should not be dismissed until she has been free from all manifestations for nine months following cessa-

tion of treatment; and even then, if she becomes pregnant, proper treatment should be advised during gestation. The future of all cases depends, to a large degree, upon the treatment conducted during the first twelve months.

Treatment.—The subject of treatment subdivides itself into prophylactic, hygienic, constitutional and local.

As the prophylactic treatment has been so ably presented and discussed, this portion of the care of those suffering from lues will be omitted. The general hygienic care is undoubtedly of the greatest importance, and possibly nearly equal to the constitutional medication. When the diagnosis of syphilis is established or suspected, its nature must be carefully explained to the afflicted individual, proper methods must be advised for the protection of the immediate family, friends, and the general public; the patient should be encouraged and buoyed up with the hope that if proper treatment is observed a cure may follow, and the ill effects strongly portrayed if it is disregarded. The diet must be carefully regulated, so that it will not only be easy of digestion but of such character as will give a system, which is soon to be subjected to the fire of a chronic contagious disease, the greatest amount of easily assimilated nourishment. If the patients are gouty or rheumatic, all sweets, wines and malted liquors must be interdicted, and dark meats rarely allowed; the natural lithia waters should be taken *ad libitum*. If they are tubercular or in a low physical condition, a diet rich in easily digested fats and carbohydrates should be recommended. Tobacco, acids, sweets and alcoholic drink or food must be interdicted, or many avoidable unpleasant complications will appear. The hours of sleep must be regulated, carousals of all kinds forbidden, and, while proper general employment of time is commended, excessive mental application and nerve-strain should be avoided. This is particularly true in those of a neurotic type, in whom worry often induces a train of nervous and mental troubles. Golf, horse-back rides and general outdoor recreations are beneficial. The teeth should be placed in good condition before the advent of the secondary symptoms, and they should be regularly and properly brushed and the mouth kept clean. Prepared salt water, sea water or sulphur baths, sponge and general, should be indulged in regularly. In fact all the hygienic methods

which tend to maintain the emunctory systems—kidneys, gastro-intestinal tract and skin—in the best possible condition should be advised, in order that the body may be able to repulse the inroads of the invading disease. At the same time, the hygienic routine should not be made so irksome that the patient will rebel and refuse to continue. Hereditary tendencies must be investigated and their influence counteracted. The patients must also be informed that they are carriers of a disease; that not only the original chancre, but all the other specific lesions, with their discharges and secretions, as well as the blood, or any normal secretion which is in any manner contaminated, are loaded with the syphilitic contagion, and capable of causing infection on coming into contact with the abraded surface of one not immune. Hence, cups, glasses, cutlery, razors, combs and brushes, towels, soap, etc., used, must be properly looked after.

During the so-called primary or initial stage mercury is rarely indicated, and when administered it is often extremely detrimental to the patient's future, though some physicians are of the opinion that when a chancre appears on the lips or fingers, its great menace to society at large demands its suppression at the earliest possible moment and at any cost. *Corallium rubrum*, *hepar sulph.*, *echinacea* and *phytolacca* are often administered with marked benefit. When the constitutional manifestations appear, mercury is symptomatically indicated. The author's personal opinion, derived from observation in the treatment of the large number of syphilitics in the Department of Public Charities and Corrections of New York City, and in his private practice, is that the best results are obtained when the drug is exhibited as follows: The cutaneous and mucous lesions yield rapidly to inunctions, though the mercurial soap, vasogen-mercury or the oleate of mercury may be substituted; the erythema and papular manifestations disappear in from one to two weeks, and only gratifying results follow. When inunctions cannot be used, the first decimal trituration of *mercurius solubilis Hahnemanni* acts kindly. These two forms are preferred in the active constitutional manifestations. One tablet of the first decimal trituration of the *mercurius protoiod*, before meals and at bedtime, is generally used in what may be called the quiescent period. In the

latter stages of the active constitutional period, inunctions or a tablet of the biniodide of mercury, $\frac{1}{50}$ grain, three times a day, are beneficial. When periosteal manifestations appear or rapid effects are necessary in brain lesions, hypodermic injections of the bichloride, $\frac{1}{30}$ to $\frac{1}{12}$ of a grain, every third day, give excellent results. The calomel hypodermics have been unsatisfactory on account of bad local effects and salivation. If mercury is given judiciously, it is often the only remedy required to effect a cure; when given injudiciously it is often productive of much harm. Great care should be given to the idiosyncrasies of the patient. The general plans so often commended, to treat all alike, seem to the author to be unscientific and often harmful. Each case must be individualized.

All are acquainted with the effects of the iodides of potassium, sodium, etc., the laurels these drugs have won in traditional medicine as alternatives, and their power when given in appreciable doses, to remove gummatous growths and to incite the healing of chronic specific ulceration, but if we conclude our constitutional treatment with them, no real cure may result, for, while they may remove the unnatural growths which have entered the tissues (driving them out or materially injuring their continuity and incapacitating their functional activity), we must look to the remedy symptomatically indicated, to restore the parts to their former usefulness, which they will do according to the ratio or rapidity in which the foreign material has been removed and the remedy is accurately prescribed. Chief among these constitutional drugs are graphites, aurum metallicum, sulphur, the calcareas, the kalis, fluoric, muriatic, nitric and sulphuric acids, lachesis, and the nosodes. The latter have been found most useful in the sequelæ or tertiary manifestations of congenital syphilis; in conjunction with the proper hygienic care and treatment, which should not be neglected, they have, in a number of cases, called back typical syphilitic babies from death's door, who finally developed into healthy, robust children.

Local treatment in well-conducted cases is generally unnecessary; sometimes it is required. It may be summarized as follows: The primary lesion or chancre must never be cauterized. Occasionally, if it is situated on the finger, the lip, the labia or prepuce, it may be advisable to surgically remove it and close

the wound with proper sutures in order to avoid an infecting ulcer, though its removal will not in any way change the general course of the disease. Chancres must be carefully cleansed with antiseptic solutions—hydrogen peroxide diluted with three times its volume of water, bichloride solution of the strength of 1 to 2000—and dusted with bismuth sub-nitrate, zinc oxide, iodoform, orthoform, aristol, calomel, or douched with a warm normal salt solution and dusted with calomel to give a continued nascent application of the bichloride. If the prepuce is long and the preputial orifice narrowed or contracted by syphilitic inflammatory induration, lateral incision of the foreskin may be advisable, to allow of the proper care of the original sore, and prevent gangrenous involvement, etc. In the female, frequent douching with bichloride, 1 to 3000, and the application of gray plaster, held in place by a proper binder, will be of local benefit, though often the original lesion will not disappear until the treatment for the general secondary conditions is well under way. Many of the mouth lesions may be avoided if the teeth are cleaned three times daily and the mouth and throat gargled with a solution composed of sodium borate, 3 drachms, tincture of tolu and catechu, each $\frac{1}{2}$ ounce, and water to make 8 ounces.

In the secondary period, the following gargle will often be of benefit: Potass. chlor., 3 drachms, powdered alum, 16 grains, aqua menth. pip., 1 ounce and water to make 16 ounces. Mucous patches, and often ulceration, may be curtailed greatly by cauterizing with argentum nitricum, 10 to 60 grains to the ounce, though better results follow the daily application after the parts are cleansed, with a saturated solution of beechwood creasote and iodine crystals. When the ulcerations are severe, packing the mouth, after proper antiseptic cleansing, with iodoform gauze twice daily, and compelling respiration through the nose may be required. Fissures and growths about the anus should be touched with the paquelin cautery and dressed with iodoform or white precipitate ointment. Papules and other syphilides, as papular syphilides, mucous patches and condylomata of the genitals must be bathed with a 50 per cent. solution of electrozone and powdered with calomel. Onychia and paronychia require frequent immersion of the parts in warm bichloride, 1 to 3000, and their continued envelopment in caps of gray plas-

ter held in place by proper finger stalls. Palmar and plantar papules and fissures are treated in a similar way, or white precipitate ointment and gloves at bedtime may be substituted. The scalp is also the seat of special local conditions. When papules only are present, the daily application of a little white precipitate ointment may be all-sufficient. The hair should be brushed for five minutes daily, and when the natural moisture is unchanged, a stimulating tonic is often beneficial.

Pustular and pustulo-crustaceous syphilides respond kindly to the mercurial-vapor baths and the local application of zinc ointment. Specific ulceration of the leg must be cleansed daily with a 30 per cent. solution of peroxide of hydrogen covered with mercurial ointment, and the entire leg and foot encased in a roller stockinette bandage. Chronic serpiginous ulceration may require the prolonged antiseptic bath, or curettement and treatment on general principles. Diseased bones must be treated by surgical methods, and the parts properly dressed.

HOMŒOPATHY IN THE UNITED STATES.*

BY GEO. B. PECK, A.M., M.D., PROVIDENCE, R. I.

ACCURATELY to register the compass of homœopathy in the United States is to-day absolutely impossible. Satisfactorily to ascertain merely the strength and resources of her battalions would exhaust alike the purse and the energy of the most determined investigator. To sketch in merest outline the positions occupied and the nature of their defences is all that can be achieved.

Previous reports to the International Congress have been based upon those made to the American Institute of Homœopathy by its Committee on Organization, Registration and Statistics. Inasmuch, however, as the Institute is directly related to a small fraction only of the homœopathic profession, statements issuing therefrom cover but a portion of the field, though confessedly the main portion. But one other source of information remains, the "Medical and Surgical Register of

* Report to the French International Congress of 1900.

the United States and Canada," published by R. L. Polk & Co., Detroit and Chicago. Despite the defects, avoidable and unavoidable, to which a work of that magnitude is ever predisposed, it is recognized authority with the dominant school and may well be accepted as such by us, for strict impartiality characterizes its preparation. Upon its fifth revised edition, issued in 1898, and the Institute Transactions for 1899, this report is based.

There are in the United States not less than 9369 homœopathic physicians, nearly all of whom have declared their faith over their own signatures. Of this number 1158 are women. Persons who profess to practice homœopathy, and also allopathy or eclecticism, or both alleged methods of treatment, were excluded from the enumeration, for "no man can serve two masters; for either he will hate the one and love the other, or else he will hold to the one and despise the other. Ye *cannot* serve God and mammon." The numerical relation of homœopaths to the great mass of practitioners, in which are included also allopathists, eclectics, physio-medicists, electro-therapeutists, hygiests, osteopaths, etc., is 12.51 per centum.

It is worthy of note that the degree to which homœopathy is established in the various sections of the United States corresponds very nearly to their respective advancement in civilization; in other words, to the amount of education acquired by the native white population thereof. For example, the illiteracy of that class in Massachusetts is but 0.8 per centum, while the ratio of homœopaths to the total number of her practitioners is 13.45 per centum. New Jersey surpasses her, heading the list with 15.16 per centum of her doctors enrolled in the new school, but the illiteracy of the *entire* white population of that State is 0.4 per centum *less* than that of the same class in the former State. Furthermore, in Indiana, with an illiteracy of 5.3 per centum in its native-born white population, but 5.5 per centum of her practitioners are enrolled among our forces, while in the contiguous State of Illinois, with a corresponding illiteracy of 3.1 per centum, the number of such physicians is 12.83 per centum. Contrariwise, homœopathy has barely secured a foothold in North Carolina, for she can claim but 0.33 per centum of the physicians, while the illiteracy of the native white population of that State is 23.1 per centum. South Carolina

makes but a slightly better exhibit, for we number only 0.36 per centum of her doctors, while her illiteracy is 18.1 per centum. Nor is there greater improvement in Mississippi, where barely 0.39 per centum of the physicians are homœopaths, but the illiteracy of the native-born white and of the total white population is alike 11.9 per centum, while that of the entire population is 40.0 per centum.

The homœopathic profession actively supports eight national societies, the identical number reported at the last session of this Congress. The American Institute, now in its fifty-sixth year, with its 1900 members, of whom at least 194 are ladies, is, of course, practically its embodiment. Its increase during the past three years has been nearly 300. Two of the other societies represent special types of homœopathy, three specialties of the healing art, and one a certain class of government officials. The eighth, though founded by an eminent homœopathist, and largely constituted of members of the new school, bears upon its roll adherents of all schools.

Two sectional societies, each deriving support from four or more States, are doing excellent pioneer work in their respective localities, as reported in 1891.

Thirty-three State societies, numbering not less than 3933 members, are as keenly alive to the interests of the cause in their several domains as they were in 1896. With these should be listed that in the District of Columbia, with 50 members, which makes a total of thirty-four societies and 3983 members. Polk reports a territorial society in Arizona, which should be entitled to equal rank, and increases the number of State societies, therefore, by yet another unit.

Eighty-eight local societies were recognized by the Institute in 1899 (an increase of two in three years), seventy-two of which report a membership of 3978. Forty-two clubs were mentioned also (an increase of seven), in thirty-six of which are enrolled 659 members. Moreover, six colleges have organized alumni associations, sustained by 4711 of their graduates, while the past internes of the Metropolitan (formerly Ward's Island) Hospital have organized an association which numbers seventy-five. Furthermore, six miscellaneous organizations promotive of the interests of homœopathy are recorded, two being pharmaceutical. In addition to these Polk mentions

four additional alumni associations, as many more clubs, and twenty-eight other local societies, one of which is the only organization of homœopathists in Arkansas, and on that account, perhaps, should assume to itself the rights and dignity of a State organization. It may safely be affirmed, then, that there are 116 local societies, forty-six clubs and eleven alumni associations supported by homœopathic practitioners, while six other organizations exist whose funds come more or less directly from their pocket-books. How many of these existed at the time of the last Congress it would be exceedingly difficult to determine.

The number of general public hospitals under homœopathic control reported to the Institute in 1899 was forty-nine, with an estimated value of \$5,600,833. Forty-eight of these had a capacity of 3754 beds, and had treated the preceding year 39,058 patients. In the few instances where two or more schools conjointly occupy the same building, one-half or one-third its capacity and valuation is reckoned according to the case. To these should be added twenty-one general private hospitals, eighteen of which are valued at \$1,063,000, while twenty contain 1075 beds and cared for 4365 patients. The total number of general hospitals reported at headquarters is therefore seventy, of which sixty-eight contain 4829 beds and ministered unto 43,423 people, an increase of 1302 beds and 15,552 patients over the number reported at the last Congress.

The special public hospitals number thirty-two, and contain 6592 beds. Thirty, with a capacity of 5883 beds, cared for 10,031 patients. The value of thirty (but not the same thirty) is \$5,468,120. The special private hospitals number eighteen, fifteen of which contain 414 beds, sixteen treated 1796 patients the preceding year, and seventeen have a valuation of \$672,500. The total number of special hospitals reported is therefore fifty, of which forty-six contain 6321 beds, cared for 11,827 persons, and are valued at \$6,200,000. This is an increase of 546 beds, but an apparent decrease of 14,778 patients as compared with our last report. This is due to the circumstance that then the institutions were reckoned as special hospitals.

Of institutions under homœopathic care twenty-six reported to the Institute, of which nineteen have a capacity of 2216 beds and twenty-two are valued at \$1,415,500. These with the

above mentioned hospitals number 146 institutions, an *increase of eight* over the total number of general and special hospitals as reported to the Congress of 1896.

In addition to these, Polk mentions forty-one general public hospitals, in which homœopathists have more or less authority (full, half or third), thirty-seven of which contain 1609 beds solely under homœopathic control; twenty-nine general private hospitals, twenty-two of which hold 440 beds; thirteen special public, of which ten contain 1924 beds; eighteen special private, of which eleven have 229 beds; also twenty-four institutions. Hence 101 hospitals and twenty-four institutions, or, generalizing further, 125 institutions are to be added to the 146 reported to the Institute, thus affording a grand total of 271. These should be classified as follows: ninety general public hospitals, fifty general private, forty-five special public, thirty-six special private, and fifty institutions. Of the hospitals, 195 contain 16,037 beds, or 6735 more than were reported in 1895. It should be borne in mind, however, that most of these institutions were engaged in the vigorous prosecution of their good work at that time.

Of homœopathic dispensaries, fifty-five reported to the Institute 272,648 persons received 722,319 prescriptions, or 61,782 patients and 245,521 prescriptions more than were reported in 1895. Thirty stated 27,169 visits had been made to outpatients. The expense of maintaining thirty-one of these dispensaries was \$32,467.48. The entire number is ten less than was reported in 1896, but, as Polk mentions twenty-four more, no fear need be entertained that this form of well-doing is becoming unpopular.

The medical colleges that acknowledged allegiance to the American Institute in 1899 numbered twenty as in 1896. They conferred in 1899 the degree of doctor of medicine on 418 candidates, and their lists of alumni display 13,120 names. The diminution of the graduating class by eighty, as compared with that of 1895, is the result of the enforcement of a higher standard of qualification, a matter in which the homœopathic colleges have taken the lead. In September, 1899, yet another college (that unquestionably will apply to the Institute for recognition) opened its door to students.

Thirty journals were published during the past year, two less

than were reported in 1896, and five less than in 1893. Possibly it is just as well that the law concerning the survival of the fittest will continue its beneficent work for some time to come. Not less than 16,608 pages of reading matter are contained in single copies of their respective issues.

A very considerable number of volumes on homœopathy, including some of exceeding value, has appeared during the past four years. The enterprise of our publishers is such that persons everywhere, especially interested, are advised prior to their advent. It would be a work of supererogation, therefore, to attempt their enumeration.

Reference to one or two other facts far different in their nature is essential to a correct conception of the position of homœopathy in the United States. Remember, meanwhile, that her adherents number but 12.51 per centum of all medical practitioners. Polk reports that in 1898 the new school had licensing boards of its own in twelve States and Territories; that in a like number the diploma admitted to practice; that in sixteen composite boards existed, six of which could not be controlled by any one school, and three others had an allopathic majority of but one; that in another State the *regular* board was obliged to call in a homœopathist or an eclectic whenever a candidate from such schools appeared before it, while in eight only of the fifty did the old school monopolize the situation. Since then some of the diploma States have established boards of licensure, but homœopathists secured at least a corresponding influence in their management. Again, it has become comparatively common for the rival schools to pool their interests in the smaller cities, and thus secure hospital advantages for both that neither could have obtained singly. Wherever funds are provided from the public treasury our Fellows demand their rights, and generally secure them. All this results from the circumstance that homœopathy's clientelage is no less influential than intelligent.

Since the last session of this august body three of our leaders have been removed by death: Reuben Ludlam, the father of homœopathic gynæcology; I. Tisdale Talbot, the bulwark of New England homœopathy, and Joseph Sydney Mitchell, the chairman of the Columbian Homœopathic Congress. Each for long years the head of an important medical school of diverse

type, ineradicably stamped his imprint not only upon the thousands of youths who came under their immediate influence, but upon the communities wherein they lived, and upon the entire profession as well. Long will it be ere their names perish from the earth!

The letter, in accordance with which this paper has been prepared, requested "a report on the improvement of homœopathy in" the United States. Since the maxim *similia similibus curentur*, first rendered intelligible and practicable by the immortal Hahnemann, depends upon a law of nature necessarily immutable, *similia similibus sanantur*, it *never* can be altered, *never* be improved! The methods of applying it may be, indeed already are, varied indefinitely, either for the better or for the worse. Advance toward perfection will be achieved on the one hand, *pari passu* with progress in allied sciences, enabling more and more accurate determination of the exact condition of a patient; on the other, by complete provings of each and *every* drug, together with the devisement of a means for rendering this knowledge more promptly available to each practitioner.

But though homœopathy cannot deteriorate, its professors may by departing from the practice of its essential principles. No stronger, no more specious temptation to deviation therefrom has ever been presented them than the methods of treatment proposed by the dominant school at the advent of the germ theory of disease; yet with commendable loyalty and marked unanimity they have stood by their colors. In 1892 the introduction of chemicals into the vagina of a parturient woman was studiously avoided by eighty-three per centum of our practitioners. That procedure was even then condemned by the leading bacteriologist in the United States, himself an allopathist. In 1897, for local treatment in diphtheria, the majority availed themselves of the comparatively innocuous hydrogen peroxide, alcohol or potassium permanganate, while eleven per centum steadfastly refused to employ any topical application. In 1899 that chimera, intestinal antiseptis, never entered the minds of eighty-two per centum of those treating cases of typhoid fever, nor did seventy-five per centum care to imperil a patient by flushing the colon. In 1896 the treatment of scarlatina had not been varied in the slightest degree

by ninety-three per centum because of modern theories concerning its nature, while scarcely a single per centum of prescriptions for internal use in any of the disorders mentioned varied from strict homœopathy. Since now in nineteen cities of the United States, during the years 1890-95, of every hundred dying in the lying-in chamber under allopathic treatment, fifty-two might have been saved had they been treated by homœopaths, and of those similarly perishing from scarlatina, forty-four; from typhoid fever, thirty-two; and from diphtheria fourteen despite the general use of antitoxin by the regulars, it is incomprehensible how any one possessed of well-developed reasoning faculties and any sort of a conscience, can forsake the only steadfast guide from sickness to health known to humanity for the empiric, charlatanic, ephemeral methods of the so-called scientific school.

Far different from these were the considerations that prompted the American Institute of Homœopathy at the session of 1899 to change the motto on its seal from *similia similibus curantur* to *similia similibus curentur*. By that act a general statement of fact, to which no one could justly take offense or even exception, was transformed into a direct positive command. No more important, no more significant procedure has occurred during its entire history, and yet very few comprehended on that day, if indeed even now they understand, the full import of their vote. By that authority, however, with which every member of an organization is bound by the deeds of a quorum at any legal assemblage thereof, each has been pledged to use, so perfectly as his capabilities may permit, in every prescription for the cure of the sick, a single remedy selected upon the principle of similars, and sufficiently attenuated at least to prevent an aggravation of the condition. Likewise the Institute is made boldly to proclaim to all the world that thus, and thus only, can health be restored promptly, safely, permanently. Adventitious though this action was, the trend of events during the past twenty-one years indicates its timeliness. With malice toward none, but charity for all, the Institute now stands the exponent of pure homœopathy. Should she ever prove recreant to her pledge, she will have already pilloried herself to her eternal shame!

ANÆSTHESIA.

BY J. WYLLIS HASSLER, A.M., M.D., PHILADELPHIA.

(Read before the Surgical and Gynæcological Society, at Washington, D. C., June 19, 1900.)

YEAR after year surgeons are seeking either to secure some combination of anæsthetics, or an improvement upon the one in use by them. The choice of anæsthetics has become entirely a local one; in a certain centre chloroform, in another ether, little heed being paid to the indications and contra-indications of them. In Philadelphia our choice is ether, and in our uniform success with it, we have concluded it to be the safest in the general run of cases. If chloroform is necessary at any time, then the combination Dr. H. L. Northrop, of Philadelphia, has given us, that of chloroform and oxygen, is our choice. So I shall confine this paper to

1. The preparation of the patient for ether.
2. The administration of ether, with the treatment of accidents during the administration.
3. The treatment of sequelæ.

In the preparation of the patient I have observed from my readings that strychnia is frequently given a few days prior to the operation to improve the condition of the heart; that a salt solution enema is administered so as to render respiratory and cardiac failure less likely; that when a nervous patient is to be calmed and a vital organ is to be saved from unnecessary strain, morphia; and to obviate an excessive secretion of mucus, to inject atropia.

From observations made the conclusion is forced upon me that the minimum amount of annoyance and preparation of a patient prior to an operation, the better the recovery. The ordinary preparations for an operation are conducive to producing a high degree of nervousness, the sudden change in diet, the shaving of parts, enemas and catheterizations, all suggest to the patients what is in store for them in the future, upsets their minds and we have an irritable case. The less you order done, the better is the result to anæsthetist.

It seems superfluous to mention concerning foreign bodies in the mouth to be removed, were it not that such omissions are met with in every clinic.

Know the conditions of the kidneys, stomach, character of the pulse and action of the heart, and your journey is half completed. The emptying of the bowels thoroughly minimizes fermentation and abdominal distention, and avoids distressing pressure on the heart and lungs.

From our ante-anæsthesia observations of pulse and color of skin we are able to note any change in heart action. Ether is decidedly an irritant to the respiratory tract, and it is claimed that frequently we have a pulmonary œdema bronchitis, pulmonary congestion and possibly catarrhal pneumonia following its administration. These conditions are strangers to me in over three thousand ether administrations. More likely are these conditions due to the non-protected surface of the body during the operation.

In the administration, anæsthetists should induce and maintain a uniform degree of anæsthesia, with the smallest amount of ether possible. In my experience, to accomplish this, the Allis inhaler, with the Northrop dropper, through which but a small amount can flow, seems best adapted.

Two methods of administration have their advocates, one by administering large amounts suddenly, the other the slow and gradual method. I consider the first brutal, unsurgical and dangerous. The slow administration is safe; the rapid method is apt to suddenly overwhelm the system. A man who can slowly drink a pint of whiskey without obvious harm, is put in danger of life if he gulps it all down at one time. If this is true of alcohol by the stomach, why should it not be true of ether by the lungs? It has been shown that the blood of the carotids after an animal has been killed by an overdose of chloroform, contains only two-thirds of the amount of the drug which is present when the animal has been slowly and safely anæsthetized.

To show the method as adopted by myself, I will explain a case as anæsthetized in the Hahnemann Hospital of Philadelphia. The patient is placed upon the table, if a ward case; private cases are anæsthetized in bed. The head is low, the chin on a level with the chest. The room to which the patient

is removed is perfectly quiet; the nurse or orderly take their position some distance from the table. The patient is then advised. The sense of a possible feeling of suffocation is explained to them, if they should experience this sensation to open the mouth and blow away the ether; to inspire slowly and deeply; to close their eyelids, and think of sleep. The cone is then placed upon the face free of ether, the subject breathes into the cone non-saturated; this alone assures their mind and quiets their nervousness. The pouring on of the ether before placing the cone upon the face causes a discouragement and fright, with resistance in the start-off, followed frequently by a difficult administration. The ether is begun by allowing but a few drops to fall upon the cone, gradually covering the entire surface, and at no time is the ether allowed to flow faster than a drop. The subjects, in 98 per cent. of the cases, pass quietly and quickly into the stage of surgical anæsthesia without any manifestation of the second stage, or motor action. During all this time the patient hears no voice but that of the anæsthetizer and his hands are the only ones that touch his body.

In alcoholic or hysterical subjects the second stage is usually present. If the patient struggles, the orderly or nurse gently place their hands upon the extremities. The restraint is not by force, just sufficient to prevent them from falling from the table or interfering with cone. It is the mental suggestion of a resisting force which compels the subject to intensify their resistance. With the patient in the surgical stage of anæsthesia, it now becomes a necessity to hold them under perfect control. Their condition must be constantly observed.

The pupil of the eye should be to the anæsthetist what the water-gauge is to the engineer. By it we can tell whether the case is receiving too much of the drug, or not a sufficient amount. If the pupil becomes large and reacts to light, the patient is not deeply under; with pupil small and non-reacting, complete narcosis; the pupil dilated and non-reacting, a suggestion of an excessive dose. By pinching the lobe of the ear the refilling of the capillaries affords reliable means of determining the condition and activity of the circulation. With these two conditions and the respiratory murmur always before me, I am able to keep full control of the case.

At times we experience spasm of the glottis and vomiting.

At no time is better judgment needed. Either the patient is allowed one whiff of air, or the cone is allowed to remain in position, and frequently the first inhalation causes a cessation of these conditions.

Trouble is experienced by anæsthetists in taking care of the patient's tongue, which causes stertor or noisy breathing. If at the outset a pillow is placed under the head just thick enough to raise it to a comfortable level, and the chin well held up, the chin resting in the palm of the hand, this can be partly overcome. Frequently a slight raising, lowering or turning of the head will afford relief.

Cyanosis is frequently met with, due to either falling back of the tongue, mucus or foreign body in the mouth; taking the proper care of them gives us the relief.

Shallow respirations can readily be overcome, either by dilatation of the rectum or inhalation of oxygen gas.

If there is a retardation in circulation, strychnia or atropia administered has given us the quickest and best success. When strychnia is used we give it low. I believe we are too much afraid of that drug. I frequently give the one-sixth of a grain, and even a third, with better success than with the one-thirtieth or one-sixtieth. When a stimulant is necessary, it should be administered low, and not repeated for an extended time, except when an extreme necessity presents itself. We are prone to stimulate too frequently.

Shock conditions are an exhaustion of the vasomotor centres, and they need rest. We cannot accomplish this by constantly worrying the patient with hypodermic injection and salt-solution enemas. Allow them to rest, with the foot of the bed elevated, and external heat. If this fails, then stimulate; if stimulation fails, infusion is our last resort, and the wonderful successes accomplished in our hospital with it has been very gratifying.

Among the sequelæ most annoying is vomiting. With the slow method of administration, the mental suggestions of the anæsthetizer, quietness of the room, the preventing of extra force to restrain the patient, our statistics show 11 per cent. of cases vomiting. If it is present, a small amount of lemonade or black coffee. Lately, I have been using acetic acid 2x in water with excellent result. With cœliotomy cases, hot water

with acetic acid every half hour; when nausea is relieved, ice is allowed. The hot water allays gastric irritability, quenches thirst, and if vomited washes out the stomach. Its early use has a good effect on the kidneys and intestines.

Oxygen inhalation has been advocated in overcoming the after-effects of ether. It is claimed that it overcomes nausea and general depression at once, prevents vomiting, consciousness quickly recovered, the breath is entirely deprived of the odor of ether in a short time, and the feeling of malaise is absent. I have used this method in a few cases, with the results as given above. I believe it to be a good method and should be tried.

SPOTS ON THE SPINE.

BY SELDEN H. TALCOTT, A.M., M.D., PH.D., MIDDLETOWN, N. Y.

(Read before the American Institute of Homœopathy, Washington, D. C., June 20, 1900.)

VIRGIL declared that he sang "of arms and the hero." We sing to-day of sin and of sinners—of men who might have been heroes, bearing arms for their country, had it not been for imprudently acquired spots upon their spinal cords.

The human spine is composed of thirty-three bones, and they are placed, in a more or less perpendicular position, between the pelvis and the skull. They are held together with a buffer-like arrangement of cartilage and tendon, so disposed as to make the spine flexible in every direction. But by a supreme action of the will the spine may be held up by its owner with so much firmness as to cause the term "a stiff backbone" to become a proverb in behalf of the courageous. The spine is at times as flexible as a rope, and again it is as stiff as a crowbar, its state depending upon the emotion of fright or the active exertion of a strenuous determination.

The bones of the spine have a two-fold function: (1) to maintain the body in an erect position at proper times; and (2) to protect from injury the spinal cord, which is the principal medium of communication between the procreative organs and the neurine batteries of the brain.

The spinal cord extends from the atlas, at the base of the

brain, to the lower border of the first lumbar vertebra, and from that vertebra to the end of the spine the cord is divided into filaments known as the *cauda equina*, or mare's tail. These filaments, or divided portions of the cord, extend to all the lower parts of the body, but an especially large and active number of nerve filaments are assigned to duty among the generative organs.

The spinal cord sends out filaments from the main trunk line to all portions of the human anatomy, including the arms and body, as well as the legs and the organs of generation. It may readily be perceived, therefore, that, aside from the brain, the spinal cord is the most important nerve aggregation in the body. Its duties deal not only with the life of the individual, but also with the prospective lives of future generations. It receives and transmits messages of warning or of action from the smallest nerve filament just beneath the skin, and from all the various and important organs of the body, on to the great brain centres of sensation, of thought and of action.

The spinal cord is the thoroughfare which bears its "innumerable caravan" of sensations to the brain, and over which, in return, gallop the couriers and forces of action from the brain to the various organs and extremities of the body. The more important the duty of a given organ, the more forceful becomes the action of the brain in its behalf. The more forceful the impulse to action, the greater the wear upon a given organ, or upon the medium of communication between that organ and the brain. As the spinal cord is subject to great uses, so likewise it may become the victim of overwear, of irritation and of exhaustion. On account of its extreme sensitiveness, and on account of the fineness of its quality and the importance of its duties, it is easily affected by extremes of heat or cold, by traumatic injuries, and by those poisonous influences which creep into the system through the avenues of heredity, or the yet broader by-ways of unwise and sinful action.

While traumatism, and exposure to wet and cold, and the strain of hard physical labor, and the effects of rheumatism, or malaria, or similar disorders, may have their influence in producing diseased conditions of the spinal cord, we are yet forced to the conclusion that the leading and principal disorders of

this organ arise from mal-use of the procreative powers of man, or by impure indulgences of a sexual nature. Masturbation may, so to speak, drain the substance of the spinal cord and leave it barren of all healthful conditions. Early marriage and immoderate indulgence may produce bankruptcy of the cord and insolvency of the spine. But the greatest danger lies in a too frequent congress with those who are suffering with sexual diseases and slow blood-poisoning tendencies. Prostitution is an unbridled indulgence in lecherous practices. It brings its own proper penalties in the form of loathsome and long-continued diseases. Association with prostitutes has neither the becalming influence nor the gentle restraint of a happy marriage. It is this lust and lechery, let loose without bridle or rein, that tends most strongly and surely both to the inception of disintegrating disease and to the slow degeneration of all the finer tissues of the spinal cord. It is also proper to state that intemperance in the use of alcoholic liquors is a frequent complication of prostitution; and the intemperate use of alcohol tends to aggravate the conditions produced by excessive and unlawful venery.

We have alluded briefly to some of the leading causes of those disorders which may be termed, in a general way, "spots on the spine." These spots are put there with tender touches by the brilliant pencil of Venus; and likewise they are laid on roughly by the rude and devastating brush of Bacchus. They are revealed by rosy-fingered Aurora at the end of protracted nights of salacious sinfulness; and also they appear after wild and reckless efforts to "paint the town red."

Syphilis is probably one of the most frequent causes of spinal disease. This may be due in part to the universality, as well as the pertinacity of the fell disorder. A professor of skin diseases in Vienna, in response to a question as to the effects of syphilis in producing insanity, replied that he did not know, and added: "The whole civilized world is syphilized." This was a broad assertion which may have been approximately true in Austria, but not everywhere. A bad boy was once compelled by his father to drive a nail into a post every time he performed an evil deed. When the boy reformed, he was allowed to pull out a nail every time he performed a meritorious act. After a while the nails were all pulled out, and still

the boy was not happy; for, as he explained it to his father, "the scars are still there." Such is sometimes the fate and condition of sober, reverend, and gray-haired deacons, who in youth persisted in putting spots on their spines!

Undue activity of the sexual organs or lubricious ways produces, or tends to produce, congestions, inflammations, and degenerations of the spinal cord. Congestion interferes with the proper circulation of the vital fluid. Inflammation is like fire; it burns, chars, ruins, and destroys. Degeneration is the condition into which the ruin sinks after it has been partially destroyed by inflammation.

One of the most common forms of degenerations in the spinal cord or the brain is an hypertrophied metamorphosis of the neuroglia. The connective tissues in the cerebrum, under the effects of syphilitic taint, become stiffened and corrugated, and in this way they press down upon and hold in bondage the tender nerve-filament and the sensitive nerve-cell until these become as helpless in their pathological struggle as was the dying Laocoön while wrestling with the serpents of Minerva.

Spots on the spine do not present a very brilliant or satisfactory appearance, but they come with leprous loathsomeness in the wake of sexual sin, and gross gluttony, and reckless exposure, and stale intemperance, even as purslane and pig-weed creep into and choke up a neglected garden.

The principal spots on the spine are developed by the various inflammations and degenerative thickenings of the coverings of the cord, and these produce scleroses and atrophies of the cord itself, irregularly and in circumscribed patches. These spots on the spine are found in association with brain disease. General paresis is a common form of brain and cord degeneration. It is generally admitted, I think, that paresis sometimes commences in the cord, and works up to the brain; while in other cases it begins over the cortex of the anterior and middle lobes of the brain, and works down. General paresis is a type of fatal disease which effects both the brain and the cord, and which is due, in the opinion of some writers, always to previous syphilitic taint. We have, however, seen a good many cases where no trace or evidence of previous contraction of syphilis could be discovered.

Spots on the spine are not always traceable to the personal

action of the victim himself. Some of the most troublesome diseases that afflict mankind come, with greater or less certainty, through the channels of heredity. It is curious how the elements of decay will lie hidden for generations in the blood of a family, and finally come forth and invade the forces of life, and bring an innocent child to its grave. But it is not more wonderful than that other fact, well-known to science, that a man's moral and intellectual characteristics are sometimes seen to reappear in the family, with perfect exactness, three generations after him. Hence, in considering these subtle and formidable diseases which afflict our fellows, we should be ready to put the blame where it properly belongs, and sometimes to divide the responsibility between a man and his ancestry, even if we do not lay all the blame upon the latter.

Spinal diseases are sometimes relieved by suitable surroundings, by protracted rest, by proper position and support, by nourishing diet, by appropriate baths, by favorable climatic conditions, and by suitable medication.

A warm climate, but not too warm, is favorable for those who are afflicted with spinal troubles brought on by early disipation. The baths of the Hot Springs of Arkansas are recommended to those who have passed the grace of ordinary water baths. Sometimes these hot mud baths seem to act as favorably upon syphilitic cases as did the waters of the Jordan in healing the skins of antique lepers.

Oil rubs, massage, and alcohol baths may prove beneficial if the patient is treated at home. A great deal of reliance must be placed upon keeping the patient in a prone position whenever he is tired and needs rest. An easy lounge or a comfortable bed, or both, should be the leading articles of furniture in the room of the sore-spine man. Some resort to stretching the body by means of an appropriate apparatus. Such means may be temporarily useful to such cases, but their long-continued use is probably of doubtful utility. Rest in bed tends to favor a relaxed condition of the spine, and that is favorable to relief and recuperation.

Among the remedies which have proved beneficial either in checking the progress of organic disease in the spinal cord, or in removing untoward symptoms, or in retouing the fibres of

the cord itself, we may name, with some indications for their use, the following:

Aconite.—Aconite may be called for in the early stages of spinal congestion, especially where there is great restlessness, and intense mental excitement, and fear of death.

Alumina.—This remedy is sometimes called for in slow degenerations of the spinal tissues. Bonninghausen reports the cure of four cases of locomotor ataxia with alumina. The leading symptoms are pain in the lumbar portion of the spine, heaviness and numbness of the extremities, especially the legs, which feel faint and tired, and inco-ordination and paralysis of the limbs.

Arnica.—Arnica is useful after contusion of the spine, while hypericum may be indicated where the nerve-tissues have been severely injured, and where there is a tendency to atrophy of the injured parts. We have under our observation a case of progressive muscular atrophy due to spinal injury, the patient having suffered with severe pain in the neck after having caught a "hot ball" while playing the American game. Dr. Seguin prophesied death within two years. The patient has lived for twenty years since that prophecy was made, and the disease has been checked, and great improvement has followed the persistent use of hypericum. This remedy is useful where spinal injuries have been sustained either in the nature of a wound or bruise.

Belladonna.—This remedy is useful where there is inflammation of the cord, where there is much beating and throbbing in the spine, and where lightning-like pains are felt in various parts of the body. Belladonna pains come and go suddenly.

Calcarea Phos.—This remedy may be given for the purpose of checking the further development of organic degeneration. This combined remedy seems to have an effect upon the entire organism. It promotes healthy action in the lymphatic system, and thus favors the hindrance of degeneration and an increase of repair.

Mercury.—This remedy is indicated when a diseased condition of the spine is readily traceable to either hereditary or acquired syphilis. In addition to localized tenderness along the spinal column, there are frequently rheumatic or neuralgic pains in the limbs and in other portions of the body; and these

pains are all worse at night. A thickened tongue that bears the imprints of the teeth along the edges, and which has a yellow and sticky coating, is another indication for the use of mercury. Some extol the use of mercury in syphilis, and some decry it. Properly used at the right time, it is a valuable remedy. In overpowering doses, after organic changes have occurred in the cord, it is not only useless, but injurious.

Nux Vomica.—This remedy is indicated in spinal difficulties where there is a tendency to paralysis on the right side. *Xanthoxylum Fraxineum* is used with occasional success where there is paralysis of the left side following spinal disorders.

Physostigma.—This has been recommended as an invaluable remedy in diseases of the spine, but thus far we have observed very little amelioration of symptoms following its use.

Rhus Tox.—This remedy is called for where there are rheumatic complications, and where the symptoms are generally aggravated by rest and relieved for a time by motion.

When the prosperous people of this great Republic come to recognize the fact that moderate living, and a reasonable compliance with the requirements of the Decalogue, will save many spines from disease, then the world will be brighter and happier than it is now. Prevention of disease is far the better course to pursue in the matter of spinal troubles. If rich folks would avoid Waldorf-Astorian luxuries they would then remain comparatively free from that condition into which, according to Hubbard, a victim of luxury frequently falls. He says that the high livers of New York are afflicted "with gout at one end, general paresis at the other, and Bright's disease in the middle." If that be true, then the spine must be a tight-rope over which deviltry, blindfolded, balances and marches from the cerebral hemispheres to the reveling nates. Again, it may be stated that the spine is a cinder path over which Passion, on a bicycle, scorches from the mons to the brain!

The time may come when seekers after health will look upon palaces of pleasure, and on luxurious and gluttonous living, as things to be scrupulously avoided. For it is probably as true now as in the days of Dante, that over the portals of the temple of caloric sin there should ever be written:

"All hope forsake, who dares to enter here."

TWO CASES OF SPASMODIC TORTICOLLIS.

BY N. B. DELAMATER, M.D., CHICAGO, ILL.

(Read before the American Institute of Homœopathy, Washington, D. C., June 22, 1900.)

J. C. S., 30 years, American. Heredity good. The personal history of the patient shows no serious sickness or injury. Some five years previous strained the back lifting a heavy trunk, but seemed absolutely recovered in three or four days. Has for some years had some trouble with the digestion, but not of a serious nature. Two years previous felt rather weak and tired; was advised to and did take a horseback ride every morning for six months; always took a cold sponge bath as soon as he returned from the ride.

Two or three months, or possibly less, after he stopped the riding, noticed, when he got at all fatigued, a feeling of weakness in the back of the neck; would pass off as soon as rested. A month or two later this changed to a drawing sensation, which increased gradually, and in about three months became an actual drawing, so that it began to turn the face a little to one side. Just at first this was only when tired, but later became constant but spasmodic; that is, the face would be drawn around over the left shoulder slowly, then held there firmly for three or four seconds, and then return to the front quickly. This movement became practically constant, without more than two- or three-minute intervals, and often not that, except when the head was supported in some way. If he rested the head on the back of a chair it would remain quiet for possibly a half hour, or if he supported his chin with his hand he could keep it quiet for fifteen or twenty minutes. There never was any tendency when lying down with head resting on a pillow.

This was his condition when I first saw him, nearly two years after he had the first symptoms of drawing. Physical examination failed to reveal anything abnormal (aside from this spasmodic action) in any part of the body. It was diagnosed as a genuine spasmodic torticollis. The treatment was entirely mechanical; I used no drugs whatever.

The first treatment was spinal extension by hanging, lasting for one minute, and increasing the time daily to twenty minutes once a day. In two months there was a decided lessening in the force and frequency of the spasm; then a brace was rigged to the shoulders, with rest for the occiput, and a spur running around the head to the chin, that would not allow the head to turn at all. This he wore first for a half hour each day, and gradually increased the time to two hours twice a day. The hanging was continued right along. Then a five-pound weight attached to a cord running over a pulley was rigged up on a door-jamb at his house, and the chin fitted into a socket to pull the chin away from the afflicted side, and thus place the muscles on a steady but not severe tension. He was directed to use this at home in the evening. After getting somewhat accustomed to it, he sat the entire evening with the weight attached.

The hanging and the brace were continued. The improvement was more rapid after commencing the use of the weight. In nine months the spasms ceased almost entirely, and the hanging and brace were discontinued, but the weight was kept up for two years before the last vestige of the trouble disappeared. It is now seven years since that time, and there is not the slightest suspicion of a return.

Mr. J. L., 35 years of age, English. Reported to me about two years ago. The family and personal history entirely negative, as was also the physical examination. For two years his head had been spasmodically drawn backward and a little to the right. The spasm in this case was not rhythmical; his head would be drawn back as far as possible, and held there rigidly for varying lengths of time—three to sixty minutes. It was constantly drawn back when he was in motion. By resting the back of the head on the back of a chair he could always in a very few minutes get it back in a natural position. The condition was so marked and constant that he could not read at all, except when head was resting on something solid, and in walking he was obliged to bend the body forward and quite low, in order to see where he was going.

In this case we commenced with the hanging, carried from one minute once a day to twenty-two minutes three times a day. There was a decided improvement in less than a month;

the hanging in this case performed the same act as the brace in the other; we did not use any brace, but in some six months had him get a Dowd Health Exerciser, which is simply a pulley-weight machine, had him sit in a chair facing the machine with what is intended as a foot-strap around his head, so that the pulley would hold his head forward, commencing with a half hour and increasing gradually to two or even three hours at a sitting.

The improvement was very rapid after beginning the pulley-weight. This case, while not cured, is now able to hold a paper and read it on the street-cars just as others do, and in walking along the street no one would notice anything the matter, except that occasionally, at long intervals, the head will be retracted for a minute or two.

Previous to these two cases I had wrestled with several others. During the last seven or eight years I have worked directly or indirectly with several others. I have worked hard to find and prescribe the affiliated remedy. I have called upon some of our very best prescribers to assist me in finding the remedy adapted to the case and to the patient; no success. I have tried surgical interference; no results practically. I have tried a large number of crude drugs, such as represented by hyoseyamine, hydrobromate by the stomach and hypodermically. With these following an injection there would usually be perfect freedom for from a half to two hours, or possibly three; but even with three doses per day for a period of two to three months, so that during all that time the patient was practically free, there was in reality no improvement at all, as evidenced by the fact that, leaving it off a single day, the spasm was as severe as it had been at any time.

I have tried electricity in various forms, strengths and methods. If I obtained any result at all I believe it was an aggravation, certainly nothing curative. I have the record of no cure of an undoubted case of spasmodic torticollis of long standing by any method except the purely mechanical. I have the records of nine cases entirely and permanently cured by the mechanical treatment.

"POWWOWING" IN CANCER, WITH A FEW WORDS ON EXORCISM IN DISEASES.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

SOME time ago I treated a woman who eventually died with a cancer of the uterus. Her husband in the course of a conversation related to me that they had also tried "powwowing" in her case, but that also with no better success than that of her medical attendants. I asked for and obtained the formula, with direction for use which I here publish:

"Take three pieces of the stalks of elder-wood, each stick being about four inches in length, with a joint in each, the pith of the elder to be white and not red. Hold the first one against the cancer, which, by the way, must not have ulcerated, placing the butt-end against the skin, repeating the following words: 'In Bethlehem our Saviour, Jesus Christ was born. He was crowned with the nails and the thorns. These nails did never fester and I hope to God that this never will. In the name of the Father, the Son and the Holy Ghost.'

"This is to be done three evenings after sundown and in succession, and this to be only after full moon. Repeat this operation three full moons, one after the other. After the formula has been repeated each time bury the sticks under the eaves of the house on the north side that the water drips on them, being careful not to move any of them after they have been buried, or they will do no good."

My patient was a Pennsylvania German. This quaint people is more or less tinged with curious old relics of such beliefs and very many of them, though they may laugh at these ideas of the old people, really half believe them. This holds true particularly amongst the country people. Now and then a relic of bygone years will crop out to fill one with reminiscent thoughts of the far past. I once treated a child who had stepped on a nail. The mother told me that they had greased the nail and carefully laid it away, wrapped in a cloth. This would recall to one the "Vaabensalve" of the old Northmen. Walter Scott refers to this in one of his poems.

Another curious method is the "measuring off" of a disease. This is practiced by the Pennsylvania Germans in Northern Ohio in the "decay of flesh" or "go-backs" as they call it, or, better said, marasmatic states. They direct that one take a string made of wax which never has become wet, and which has been spun by a child under seven years of age, which has never seen its father. With this the child is measured in different parts of its body, and a certain formula repeated over it. I never have been able to learn these words.

There are also formulas for worms, for colic in horses, for felons on the hands, for burns, scalds and erysipelas, as well as for snake-bites. I reported a few of these some years ago in this journal.

Prof. Axel Johannessen, of Norway, in 1897, published some curious remarks at the end of a work on rhachitis in Norway, which were quite interesting to me for they referred to this very subject, the treatment of disease by exorcism, amulets, etc.—*Bidrag til Studiet af Rakit tilligmed en del Oplysninger om Almuens Behandling af denne Sygdom*. He following the division of Bishop Dr. Bang—*Gjengangere—fra Hedenskabet og Katholicismen efter Reformation*. *Theologisk Tidsskrift, Ny Raekke*, 10 Bde., 1885, S. 20f.—finds the formulæ to consist of three different parts, which at times may appear alone:

1. *The name of the Trinity*, written on a piece of paper and carried about on the person of the sick individual or animal. The cross mark which was supposed to increase the power of the formula is derived from the liturgical books which the Catholic priests used in the churches, and which indicate when the priest should make the sign of the cross. In all the formulæ and incantations of the christian magi the name of the Trinity, and the sign of the cross are used.

2. *Mystic Words*, which are regarded as having a powerful influence, and to a great extent are employed on amulets and in books on the Black Art. Most of them are uninterpretable. Many of them are variations of a formula noted in Skaabu in Gudbrandsdalen, Norway, as follows:

Lic Týro Lammo
Syd mo me aigt
Tonnis. Amen.

This formula is found in several works on the Black Art,

thus one from Malmoe, 1771, with the title: "Fra onde Menesker Fravarelse," as well as in M. Lorenzen's, *Signeformularer og Trylleraad* (Formulae for Practising Witchcraft), published in Aalborg, 1872.

3. *Counting off*.—"Aftaelling" or "Abmessen" of the Germans, which in practice is often accompanied by measuring, whose principle is that the disease or its power is decreased by counting lower and lower until finally nothing is left.

Along with this belief there is another and older one, which has served to spread the practice of "Aftaelling;" the idea that if the formula be read backwards the hold of witchcraft will be broken. If Our Father (the Lord's Prayer) does not help, said in the usual manner against the evil spirits, it should be read backwards, and, if with the aid of the Black Art, the devils or spirits have been loosened or expelled, they may be bound again by reading the formula backwards. This belief is met with fully developed amongst the nations of classic antiquity, and has persisted down till our days. Therefore it was used in the treatment of disease which the people thought to be due to evil spirits. The mere "Aftaelling" itself is very old. For example, to measure "sand" out of the eyes, the patient stares at one with open eyes, and the exorciser counts backward to 0.

To drive away toothache the witch-man takes a stick, and the patient leans against it with his aching tooth. The exorciser writes with a stick, not with a pen, on a piece of paper—Eli 8, Eli 7, Eli 6, Eli 5, Eli 4, Eli 3, Eli 2, Eli 1, and lays the paper somewhere where no one comes.

To measure off another disease:

"N.N. e maele for Mosott,
ifraa nie te otte,
ifraa otte te sajau,
ifraa te seks,
ifraa seks te fem,
ifraa fem te fire,
ifraa fire te tre,
ifraa tre te tvau,
aa derifraa te aitt,
aa so te inkjevetta."

This latter is from Hallingdal, in Norway.

Another method of diagnosing and of treating rhachitis is known in Scandinavia as "Stoebning." A little lead is melted

in a spoon and poured into water. According to the figures which the hardening metal assumes, the source of the witchcraft is determined. Thus the child may be affected with witch-marasmus, earth-marasmus, stone-marasmus, hereditary-marasmus, even water- or fish-marasmus, here is one formula:

“Svek, som gjoer Skraek,
jeg blaeser dig vaek,
med Smidjens Baelg,
til Troldens Svaelg,
Jeg driver dig ned i dette Vand,
Jeg driver dig ud i Havets Sand.”

The following is a similar Low German formula:

“Englische Krankheit, verschwin,
Wie de Dau an de Sween,
Wie de Kuku voer den Saevenstern.”

“Wenn ein Kind das Abnehmen hat, das Kind muss Morgens gegen der Sonnenaufgang getrangen werden, Dann sprich:

“Sei mir Gott willkommen, Sonnenschein,
Wo reit'st hergeritten?
Hilf mir und meinen lieben Kind,
Gott, den heiligen Vater, bitte,
Dass er mein Kind hilfe;
Bitt'den heiligen Geist,
Dass er wolle geben meinem Kind
Sein natuerliches Blut und Fleisch.”

Johannesen states that the measuring referred to before is done with a woolen thread, from the crown of the head to the sole of the feet, and over the outspread arms, from the tip of the fingers of one to the other. This is done on both the fore-and back-side of the the body. The greater the variation between the length of the body, and the space between the finger tips to finger tips, the more the disease has advanced. The measuring should be often repeated that one may see if it has advanced or not. After each time the string should be buried in the earth or burned, and only after the patient has worn it for three days and three nights on his left arm.

He also gives a very old Latin formula for sore throat:

“Praecantatio ad faucium dolorem.”

Septem tusella, VI tusella, V tusella, IIII tusella, III tusella, II tusella, I tusella, tusella nulla.

Another formula is given in Swedish :

“ Ref orman hafve doettrarne nio,
De nio blefvo aatta ,
de aatta blefvo sju ;
de sju blefvo sex
OSV.
de tvaa blefvo en,
den ena blef ingen.”

THE DIAGNOSIS AND PREVALENCE OF ORAL AND PHARYNGEAL SYPHILIS.

BY W. A. WEAVER, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club, June, 1899.)

IN this paper it is my purpose to dwell mainly upon the local manifestations that would, under varying circumstances, lead to the diagnosis of syphilis in the cavities of the mouth and throat. Also to make slight reference to the alarmingly high percentage of syphilis as found among nasal and pharyngeal diseases.

It is generally conceded by physicians, but more especially those engaged in all departments of dispensary practice, that the 2 or 3 per cent. of diseases heretofore attributable to syphilis by medical writers is far below the percentage or actual condition as found to-day. It may be stated with certainty, and substantiated by hospital statistics, that the percentage of those infected is increasing each year, due not only to vice and profligacy, but also to the complete disregard for the safety of others on the part of those infected. There are hundreds of innocent and virtuous people infected each year, in the largest cities particularly, due to the fact that many depraved and unprincipled victims occupy, during the virulency of the disease, positions in leading hotels, restaurants, factories and private families as waiters, nurses, or domestics, contaminating table linen, drinking-cups or toilet articles, and by using these, inoculation takes place. It is plainly seen that

it would be a great injustice to place a moral stigma upon all those having this disease, even if we know the percentage thus infected to be small.

We have all learned that the statements of those infected, in many instances, are not to be relied upon at all, for syphilitics are "notorious fabricators" in everything pertaining to their disease, but may be perfectly truthful in all other matters. We, therefore, in making our diagnosis, should be governed entirely by the local lesions or appearances, with as many general symptoms as can be elicited, remembering that no class or condition of society is exempt from this malady.

The prevalence of this disease among throat and nose affections may be shown by the records taken from the book of which I have charge in this department at the Hahnemann Dispensary. The other books of this department, of recent date, would show about the same percentage if examined. The cases are called in the order in which they come, children and adults alike. There are a few more than four hundred cases recorded in this book, of which 92 have syphilis, or nearly 25 per cent. of all the new cases were found to be in one of the three so-called stages of this disease; the majority, however, being in the secondary or virulent stage. This is an alarming condition of affairs, and should lead every physician to examine all suspicious cases with every precaution, especially in dispensary practice. Repeatedly cases have been sent to our department who have been carelessly examined by physicians using ordinary tongue-depressors, spoons, or possibly the finger or a pencil, to obtain a view of the throat in which there existed mucous patches in many portions of the mouth. If these mucous patches cannot be readily recognized by the examiner, it would be well to consider all cases of ulcerated stomatitis as specific, so that mutual safety would be assured, and especially that the physician would not inoculate himself by injudicious examination or treatment. We are cognizant of the fact that all departments of dispensary practice do not have the same rate of percentage, nor do general practitioners, as above referred to, in our department; but it should be remembered that of the 400 cases many were children, and also that there exists in this climate a great deal of chronic nasal and naso-pharyngeal catarrh. It is evident,

therefore, that if this department was for adults only, there would exist a very much higher percentage than the one above given.

Diagnosis.—Before entering into the consideration of the local manifestations, permit me to rehearse a few general symptoms which, if they can be truthfully elicited, will aid greatly in diagnosing the case. History of a chancre, recent or of a longer interval of time; lymphangitis, sore throat, glandular enlargements, epitrochlear or cervical, erythematous syphiloderm, alopecia, periosteal pains, or headaches with nocturnal aggravations, excruciating at times, hoarseness, painful deglutition, complete aphonia at times, an unmistakable odor of the body and a fetor of the breath.

The initial lesion or primary stage we are infrequently called upon to treat. If a chancre is met with, it is usually found upon the inner portion of the lip, near or at the angles of the mouth, or on the tonsils, or on the pillars of the pharynx. They differ but little in appearance from a chancre of the usual location. A vesicle or papule first appears, which enlarges slightly, then gradually thickens and hardens, especially at the base and edges. The inner portion soon breaks down, forming an ulcer, the base and edges of which are hard and gristly. The indurated tissue about it consists of a dense infiltration of small and large giant epithelioid cells. Upon restitution, the major portions of these cells are necessarily absorbed.

The lesions in the mouth and pharynx found in *secondary syphilis* are those to which we wish to direct special attention. In this stage are many local manifestations in the mouth and throat. The sore throat may be one of the first symptoms that attract special attention on the part of the patient. In many instances the primary lesion will be lightly thought of; it is only at the appearance of the throat symptoms that the patient becomes alarmed. At first there appears a diffuse uniform hyperæmia over the fauces, arches and pharyngeal wall, differing from an ordinary catarrhal inflammation in that the redness is less intense. Shortly this congestion disappears, and is followed by the erythematous or mucous patches which are characteristic of this disease and which may occur over the entire buccal cavity; but, in location, occurring most frequently in the following order: tonsils, pillars of the fauces, sides and base of the

tongue, lips, inner cheeks, and tip of the tongue. Lesions of this stage are very infrequently found upon the pharyngeal wall. These patches are very slightly elevated about the edges, with a slight areola of congestion, seldom any infiltration. They are circular or elliptical in form, are frequently symmetrically arranged on both sides of the tongue or pharynx, at first a red border with a whitish hollowed centre having a bluish-white coating, somewhat resembling an eschar from nitric acid. Beneath this membrane, if removed, an irregular, slightly furrowed, light pinkish or grayish surface remains, the borders of which are distinctly outlined with a small areola of congestion, or at times slight infiltration. If they are allowed to progress they not only interfere with mastication and deglutition, but the inflammatory tissue widens and deepens to possibly several millimeters, thus becoming very painful upon speaking, or from the presence of any liquid or food in the mouth. If present upon the tonsils they may extend over a large portion and to quite a depth, but not involving as much of the tonsillar tissue, and not having the infiltration that exists in the tertiary form—important differential appearances.

The tertiary lesions which occur from two to forty years after the initial sore are less difficult to diagnose, having more fully outlined and distinct ulcerations. They are usually preceded by gummata or gummatous deposits, which appear as small hard nodules beneath the skin or mucous membrane. These enlarge and undergo degeneration and softening and finally break down, producing the well-known ulcer of this stage. They are usually deep, cup-shaped depressions, with sharp-cut indurated and sometimes undermined and ragged edges. The locations of the more superficial ulcers are upon the base of the tongue, the inner portions of the cheeks and the pillars of the fauces. The deeper ulcerations occur upon the tonsils, velum-palati and pharyngeal wall. The borders are irregular, sharply defined, and are of varying degrees of depth. The destruction of the tissues of the throat is so alarmingly rapid, at times, and so insidious in its onset, that the greater portion of the soft palate or pharyngeal wall may be gone before the patient is greatly inconvenienced or alarmed by it. I have seen them of so great a depth upon the pharyngeal wall that the outlines of more than one of the cervical vertebra could

be made out and the soft palate nearly all gone, allowing the vault of the pharynx to be seen without the aid of instruments. These ulcers are partly filled with a thick, foul, muco-purulent or stringy secretion, which if carefully removed will leave a pale, irregular, or furrowed surface beneath. If they are not early recognized and vigorous anti-syphilitic treatment instituted, not only will the mucous, cellular and muscular tissues be destroyed, but the bony structure of the pharynx, the hard palate and nasal bones will become necrosed, destroying the contour of the face and throat, altering voice-production and resonance. When cicatrization about the soft parts occurs, adhesions often take place, in consequence, between the edges of the palate and pharyngeal wall, with subsequent contractions and narrowing of the naso-pharyngeal space. The extent of the ulcerations and contractions may be so great that not only vocalization but respiration and deglutition may be seriously interfered with, rendering some patients totally unfit for any vocation which necessitates the use of the voice. Very little pain is associated with these ulcerations, except in certain localities where the normal action of muscles is interfered with.

Differential Diagnosis.—There are a few local and constitutional diseases which closely resemble the lesions of syphilis, the most prominent of these being tuberculosis, ulcerative stomatitis, lupus and malignant growths.

Syphilis and Tuberculosis.—The differentiation at times in certain stages is impossible. Shortly they become more clearly defined and more widely separated, positive proof of syphilis being established by improvement from anti-syphilitic treatment. In tuberculosis no improvement, and frequently the process hastened. The tuberculous patient is usually anæmic, weak, emaciated, with rapid loss of weight, cough, night-sweats, and presence in the sputum of tubercle-bacilli. In syphilis, history at some time of alopecia, cutaneous eruption, fetor of breath, a ruddy complexion and healthy appearance. *Locally*, syphilis has the infiltration or inflammatory area about the ulceration. Very little pain. *Tuberculosis*, pain constant but increased upon deglutition, area surrounding ulcer anæmic.

Syphilis—Ulcers usually multiple, red areola extending from one to the other frequently.

Tuberculosis—Less frequently multiple, very irregular in outline and of less depth.

Syphilis—Deep ulcers with overhanging edges, located at the sides of the mouth.

Tuberculosis—Usually not deep and more centrally located.

Syphilis—Rapid in progress.

Tuberculosis—Much longer period of time to have same area involved.

Syphilis—Ulcers show tendency to heal quickly, with marked cicatricial deformities.

Tuberculosis—Heal very slowly, with little or no deformity.

Syphilis—Mucous membrane red or purplish.

Tuberculosis—Pale, anæmic.

Syphilis—Posterior cervical gland affected.

Tuberculosis—Never affected. The anterior cervical glands may be, but posterior never.

Malignant Tumors.—More extensive induration of parts affected and adjoining glandular enlargements more marked. Slower progress of the ulceration, requiring weeks for development. Frequent occurrence of sharp lancinating pains, independent of motion, a sanious discharge, cachexia, history and results from treatment different.

Lupus.—Nodules also in the integument, very slow course, little odor, weak and tuberculous subjects, attack only cartilaginous tissue.

Ulcerative Stomatitis.—Gastric disturbance, rapid onset, ulcers superficial, ulcers not surrounded by areola of congestion but situated upon a surface of general redness, extremely painful, rapid course and readily relieved.

In conclusion, I wish to add that it would be safe and better for all concerned to treat every case of prolonged sore throat, where there are ulcerations upon any portion of the throat or mouth, if they are deep, irregular, rapid in progress, ragged edges, with a slightly elevated and indurated base, as that of syphilis. Failure will be seldom noted in these cases if treatment is followed carefully. In no class of cases have I seen such beautiful and prompt results follow, and in some of the worst forms, after vigorous anti-syphilitic treatment had been closely adhered to for a little time.

KALI HYDROJODICUM IN SYPHILIS.—A valuable remedy for constitutional syphilis, especially affections of the bones and of the skin, particularly if the patient has been drugged with mercury.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE NEW ENGLAND STATE BOARDS.

It is possible that some of our readers are not as deeply impressed with the importance of the subject of State Boards of Examiners as we are, and may, therefore, find our frequent recurrence to the same theme monotonous. We regard the movement, but one of many similar ones, as an attempt to transplant to American soil a plant of foreign growth, to substitute the paternal idea of government for the indigenous American one of self-government. We see this idea acquiring more and more force here in America, under the guise of progress, while abroad it is a surviving relic of previous more stringent conditions.

If the State Boards have "come to stay," as is declared by their advocates, then it behooves every member of the profession to see to it that they "stay" in a form and with only such powers as do least violence to the spirit of our institutions, curtail as little as possible the rights of the individual, and impose no unjust restriction upon the exercise of these rights.

The system must be regarded as an exotic, as still unacclimated, and confessedly imperfect. None of its single-minded advocates can or will object to honest criticism of the principles underlying it, or of the manner in which these are carried out. Rancor and ill-feeling aroused by such criticism can have their origin only in a consciousness of weakness; the shoe pinches; the cap fits. Truth fears no criticism, but invites the closest scrutiny. That which cannot bear criticism is on that very account worthy of the most destructive animadversion.

The thoughts which we wish to present this month have been suggested by reading the "Abstract of Proceedings," of the First Meeting of the Confederation of the New England States Medical Examining and Licensing Boards, as it appears in the *Monthly Bulletin* of the State Board of Health of Rhode Island, February, 1900.

The main purpose of the meeting was to discuss the best means of obtaining reciprocity. It was the view of the president, Dr. M. Mailhouse, of Connecticut, that the best result could be gained from having in each State a single board of medical examiners. At present Maine has a single mixed Board, of six members, "not more than two of whom shall at one time be members of any one chartered medical society." New Hampshire's Board "consists of three boards and a joint board of all three, making a total of fifteen when assembled jointly." Dr. Gerald, one of the framers of the law, "saw no reason for changing from three boards to one." Vermont has three Boards, "with at present no concerted action between the three." Massachusetts has only one Board, which includes two "regular," three homœopathic and two eclectic physicians. In Rhode Island the State Board of Health constitutes the only Board of Examiners, and consists of three "regulars" and two homœopaths. Connecticut has three Boards.

As to the question of reciprocity, there is no doubt that the profession is gradually awakening to the injustice and hardship of the present arrangement, based, in the first instance, upon the old doctrine of States' Rights, and strengthened and justified by the demand for uniform requirements. Reciprocity is, in our opinion, the first object to be sought; the question as to the best means of obtaining this is of course still open for discussion. Dr. Wright (Conn.), said, "I have attended several conferences of the National Board of Medical Examiners. The meetings consisted of an acrimonious discussion upon preliminary education, and reciprocity was not considered at all."

This naturally brings up the question of preliminary education. There cannot be a reasonable doubt in the mind of any candid person that one who has been trained to study is better qualified to undertake the study of medicine than one who has not had this advantage, but there is room for a very wide, honest difference of opinion as to the best means by which this training may be acquired, and the proofs by which its possession may be demonstrated. Apart from this, we have all along maintained that the establishment by a medical council of a standard of preliminary education which must be acquired before a student may enter a medical college is illogical, is

without the province of any outside council, and is a direct infringement of the rights of the colleges. These, and these alone, have a right to determine the fitness of the applicant for matriculation. The Boards are to decide upon the fitness of graduates to be licensed to practice medicine; it is not their concern, according to the alleged purpose of their creation, to seek to elevate the standard of culture and education in the profession. They are not called upon to pose as the advocates of higher education in general, nor even among the physicians. They may seek to elevate the standard of *medical* education, and in doing so they have found and will continue to find the colleges ready to co-operate. Surely no one can accuse us of undervaluing the widest education and the broadest culture in a physician, but we are not prepared to seek to advance these by unjust methods. The fact, emphasized by some, that the greatest number of failures to pass the Examining Boards occurs among those deficient in "preliminary education" is only an argument for our view of the subject, since it shows that a properly conducted examination will weed out those in whom this deficiency has been detrimental to the acquisition of a "fitness to practice medicine."

This logical view is held in Maine, Vermont, Massachusetts, Rhode Island and Connecticut, even to the extent that it is not requisite that the applicant for examination be a graduate of a medical school. In Rhode Island a certificate is granted, without examination, to applicants from recognized medical schools. This is as it should be. Any one supposing himself fit to practice medicine should be allowed to present himself before an Examining Board, and, if this finds him competent, he should be granted a license to practice, no matter where, when, or how he has acquired this fitness. If the Board cannot decide without having a sworn statement as to what the applicant knew *before* he began the study of medicine, then, in our opinion, the resignation of that Board and of all like it would be in order.

The colleges, when they find that their curricula have developed to such an extent that it is manifestly impossible for an ignorant or poorly educated student to pass through the course of study with credit to himself or to his Alma Mater, will naturally and in self-defense elevate the standard of preliminary

education required of their matriculants. This has been done, we think, in all cases—indefinitely in some, in others definitely, by demanding the degree of B. A. of its matriculants. Such action is logical, and the outgrowth of natural conditions, while the interference by Councils is illogical, artificial, and, when we examine their requirements—absurd.

One little item before closing. In Maine, Vermont, Massachusetts, Rhode Island and Connecticut (by the “regular” Board) the applicant is not required to certify that he has not seen the questions presented, but in New Hampshire, and by the homœopathic Board in Connecticut, he is required to do so. In Maine, New Hampshire, Massachusetts and Connecticut applicants are informed at the beginning of the examination that they will be dismissed if found communicating with each other, or if found using notes. In Vermont and in Rhode Island this threat is mercifully omitted.

In view of the late scandal in Pennsylvania in connection with obtaining the questions beforehand by fraudulent means, it would seem almost like irony for us to express our approval of the two latter Boards in failing to consider all applicants as dishonest persons who are waiting only to follow the natural bent of their wicked hearts. Ludicrous as it may seem, we still believe that man is not altogether bad; that there may still remain some sparks of honor in the human heart even after a four years’ course in a medical college. Aspersions on this honor, well deserved in some cases, perhaps, are not calculated to put the minds of the others in a fit frame to undergo the ordeal before them. We believe that in all but the utterly depraved, trust begets honesty.

There are some other points suggested by the Report to which we will refer hereafter.

THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA.

THE Homœopathic Medical Society of the State of Pennsylvania will convene in annual session at Wilkesbarre, Pa., September 25, 26 and 27, 1900, and will continue in session until its business is transacted. The Wilkesbarre meeting will be an

important one, and calls for a large attendance of physicians from all parts of the State. This being the year preceding the biennial session of the State Legislature, special thought and consideration must be given to providing ways and means for furthering the project of establishing a State asylum for the insane which shall be in charge of homœopathic practitioners. All the insane asylums of Pennsylvania are under the care of members of the allopathic school. They are all disgracefully overcrowded, and the results are such as to cause regret when necessity compels us to send one mentally incapacitated to their charge.

The members of the State Legislature are liberal, fair-minded men, and willingly recognize the just claims of all classes of citizens.* They do not comprehend or realize that previous legislation has created and established a State medicine. When they do, they will call a halt and correct the evil, and extend equal care and protection to all classes of citizens alike, with special privileges to none.

There is imperative need for a new asylum, and it will be provided for at the coming session of the Legislature. It therefore becomes the duty of the Legislative Committee of the State Society to give special attention to this matter, and to carefully mature a plan of procedure for the members of the Society, and to again lay before the State Board of Charities a request for a Homœopathic State Hospital for the insane; and the members, on their part, should assure the committee of their individual and united support and hearty co-operation in whatever steps the committee may find necessary to take for the purpose of obtaining the grant of such an institution. A united, well-sustained systematic effort along a well-devised plan of action will bring a successful issue.

The scientific work of the session will be of excellent merit, and the Wilkesbarre physicians are making special efforts to provide ample entertainment for the visiting members and their friends.

For the business details, the place of meeting, hotel accommodations, and all other necessary information, the reader is referred to the news-pages of the present number of the *HAHNEMANNIAN MONTHLY*.

GLEANINGS.

INFECTION THROUGH THE TONSILS AND ITS RELATION TO RHEUMATISM.—In the Wesley M. Carpenter lecture, F. A. Packard, of Philadelphia, concludes an exhaustive study of infection through the tonsils with the following summary:

1. The tonsils are active and useful organs, whose function it is to offer a barrier to the entrance of organisms into the deeper tissues at a point which, by its location and construction, is very open to infection.

2. The tonsils act in this respect as do other lymphadenoid tissues in the body, as is best exemplified by the lymphatic glands.

3. That during the course or following tonsillitis, we may have occurring most of the important complications of typical acute articular rheumatism.

4. That acute articular rheumatism is an infectious disease, dependent possibly on no one organism, but upon a variety of bacteria.

5. That the phenomena of rheumatism can be accounted for by toxin-absorption.

6. That the toxin causing rheumatism may be produced by an attenuated micro-organism.

7. That it is possible that the frequent entrance of the micro-organisms by way of the throat may explain the fact that we have acute articular rheumatism developing, after an invasion of the throat, rather than the ordinary septicemia or pyemia, for the reason that there is situated a collection of lymphadenoid tissue, capable of restraining the growth and virulence of micro-organisms attacking the membrane which it protects.

8. That the terms rheumatic pleurisy, rheumatic purpura, rheumatic erythema, and rheumatic sore throat should be used with less freedom, and that it would be more correct to look upon them as the result of infection, whether accompanied or not by articular phenomena, rather than as latent, aborted or incomplete forms of a condition produced by an unknown, mysterious and intangible rheumatic poison.—*Phila. Med. Journal*, April 28, 1900.

F. Mortimer Lawrence, M.D.

RHEUMATISM AND THE ARTHRITIDES.—In a discussion at the recent meeting of the American Medical Association, Packard, of Philadelphia, remarked that rheumatism covers many diagnostic sins, just as dropsy did at one time. Rheumatism is not a local disease. Arthritis, endocarditis, etc., are not rheumatism. Acute articular rheumatism is a well-defined series of signs and symptoms produced by an unknown ætiologic factor, with a great tendency to attack the nervous membranes, notably the endocardium. Arthritic diseases may be classed as (1) acute articular rheumatism; (2) acute infectious arthritis, seen in gonorrhœa and in scarlet fever; (3) chronic infective arthritis, seen in children; (4) rheumatoid arthritis; (5) the spinal arthropathies; and (6) the arthritis of gout. Articular rheumatism is an infectious process that

may be caused by one of various organisms entering the system, often from the throat.

Musser, of Philadelphia, said that acute articular rheumatism is undoubtedly an infectious process. Many joint cases are of toxic origin. In many cases skin lesions, which may be of gastro-intestinal toxic origin, are associated with joint lesions.

Anders, of Philadelphia, said that acute articular rheumatism is not an arthritic disease; it is unquestionably infectious. The cardiac complications are always infectious and will be found to be due to a toxin. Chorea and rheumatism are not ætiologically related.

Bishop, of New York, believes that there is a disorder of the chemistry of the body, a disorder of the process of nutrition, as well as an infectious aspect in the development of joint diseases. He prefers classifying these diseases according to this system: (1) infectious arthritis, as acute articular rheumatism; (2) arthritis due to chemic changes, as gout; and (3) arthritis due to nutritional changes, as arthritis deformans. These three classes of changes may exist in the body coincidentally.—*Phila. Med. Journal*, June 9, 1900.

F. Mortimer Lawrence, M.D.

ALBUMINURIA AND NEPHRITIS IN SKIN DISEASES.—Dr. Pechkranz, in one hundred and twenty-eight cases of scabies, with secondary eczema in twenty-four cases, with the usual reagents, as nitric acid, acetic acid and the cyanide of potash, albumin was detected; in eight, considerable free albumin was noted, one with a few hyaline casts, and in four undoubted signs of Bright's disease were observed. This was noted before any treatment had been instituted. As nearly all the patients were young, both arteriosclerosis and leucorrhœa could be excluded, though possibly some of the cases are to be reckoned as the so-called physiological or cyclic albuminuria. In the majority no infectious disease, as scarlatina, diphtheria, etc., had preceded, and the quantity of albumin was too great to be reckoned as due to cyclic albuminuria. Abuse of spirits, cold bathing, etc., also could be excluded. Thus, a connection between the skin disease and the nephritis does seem possible.—*Weekblad van het Tijdschrift Voor Geneeskunde*, No. 15, 1900.—(Dr. Samuel West—*Granular Kidney and Physiological Albuminuria*, London, 1900—has paid quite a bit of attention to this matter. He divides the skin manifestations of granular kidney into rashes, with and without œdema. The latter are probably toxic in origin. Of these latter he has noted: Erythema, pityriasis, dermatitis exfoliativa, general eczema, a discrete papular eruption, sometimes lichenous, sometimes resembling chronic urticaria. Illustrative cases accompany his remarks on each condition. This is a very excellent little work.)

Frank H. Pritchard, M.D.

TREATMENT OF MALIGNANT LYMPHOMA BY INTERSTITIAL INJECTIONS OF ARSENIC.—Dr. Drobnik, on account of the unsatisfactory results which surgical treatment yields in these growths, and which has been found to be difficult, dangerous and of little avail, tried interstitial injections of arsenic, though it must be said that they had been used before him and without encouraging results.

The case was that of a young woman of 23, with large glands in the axillæ and submaxillary regions, which were confluent, in hard and voluminous

masses, which could not be enucleated. Once a week she received an injection of: Sol. Fowler 1.25; alcohol, distilled water, āā, 5.0; carbol. acid, gtts. iij. After a few weeks the tumors had markedly decreased in size, while certain of them had wholly disappeared. The favorable results obtained in so short a time would lead one to give it a trial.—*Przegląd Chirurgicalny*, tom iv., Zeszt 3, 1900.

Frank H. Pritchard, M.D.

EXTRACT OF CHELIDONIUM IN CANCER OF THE FACE.—Dr. Pekoslawski reports the case of a peasant of 53 years who, nine years previously, had noticed a nodule appear on the ala of his nose, which had been excised four years ago at the Surgical Clinic. When seen the ulcer was five cms. in diameter, and after it had been curetted and cauterized it began to granulate, but without appearing to cicatrize. He then injected the extract of chelidonium in glycerine as well as dressed the wound with the same on gauze. After six injections and twenty dressings the ulcer cicatrized. No histological examination was made.—*Ibidem*. (Dr. Kossobudzki, in a man of 50, who suffered from an epithelioma of the lower lip, applied the extract of chelidonium locally, ten ounces in all, in potions, pomades and in injections (66), without any results having been obtained, so that an operation was necessary.—*Ibidem*.)

Frank H. Pritchard, M.D.

TRAUMATIC PNEUMONIA, PRODUCED BY CONTUSION.—Dr. G. Reynaud calls attention to the rarity of this variety (4.4 per cent. of all kinds). The fugacious and nearly always benign symptoms form a definite variety, and the presence of pneumococci indicate it to be lobar. Nearly always it is due to direct contusion of the chest-wall, while individual resistibility varies according to whether one be an alcoholist or has had previous attacks of pneumonia. From observation of two cases, one in a spirit-drinker and the other in a subject of lead-poisoning, he directs attention to the facts that, besides the violent pain in the side and the profuse hæmoptysis, the fever may begin without an *initial chill*, be low and of short duration, and fall *by lysis*. The patient is but little confused in mind, but yet relatively quite decidedly so in relation to the whole course. Stethoscopically, there is a complicated mingling of crepitating, subcrepitating and sibilant râles, heard simultaneously with moderate bronchial respiration which are characteristic for traumatic pneumonia. In no case was the sputum rusty.—*Hospitalstítende*, No. 9, 1900.

Frank H. Pritchard, M.D.

TREATMENT OF GRANULAR CONJUNCTIVITIS BY LOCAL APPLICATION OF TINCTURE OF IODINE IN GLYCERINE.—Dr. Fotinatos, of Alexandria, claims that this disease of the eyes was known at the time of Hippocrates, and due to the micrococcus trachomatogenes, and is transmitted by direct contagion. It is very frequent in Egypt amongst the Arabs, who live in filth and in unsanitary conditions, while the excessive heat, humidity and dust all contribute. A cure is difficult and requires time. The eyes should be cleansed with clean cotton or that dipped into a 5 per cent. solution of carbolic acid. Internally, he advises a restorative regimen and remedies for the morbid diathesis. Locally, he has had marvellous results from a mixture of equal parts of glycerine and tinc. iodine.—*La Grèce Medical*, No. 3, 1899.

Frank H. Pritchard, M.D.

TREATMENT OF EPITHELIOMA OF THE FACE BY LOCAL APPLICATION OF ARSENIC.—Dr. Hermet recently exhibited before the French Society of Dermatology and Syphiligraphy several patients who were under treatment for epithelioma of the face by local application of arsenic—the Cerny-Truncceek method. The recurrences appearing in the cicatrix, it is best to scarify before applying the caustic. M. Brocq has used this method, but has remarked a tendency to recur. M. Danlos states that this caustic gives definite recoveries and exercising an elective affinity for the cancerous tissue, it is “an intelligent caustic.” In those cases where surgical treatment is refused or impossible it is usually accepted by most patients. Then there are cases where it has given good results where other means have failed.—*La Semaine Médicale*, No. 7, 1899.

Frank H. Pritchard, M.D.

RECURRING CATAMENIAL HERPES AND POLYMORPHOUS ERYTHEMA WITH PECULIAR ALTERATIONS OF THE BLOOD.—Dr. Leredde recently reported the case of a woman 33 years, who for fifteen years has been subject at the menstrual periods to eruptions of confluent herpes, in patches on the face. Generally there at the same time appears a polymorphous erythema upon the hands; at times purpuric spots are noted on the legs. Often rheumatoid pains accompany these manifestations. The blood of this patient exhibits curious alterations: The red corpuscles are slightly diminished, while the white ones are sometimes increased. The hæmoglobulin is diminished in quantity, there is a slight eosinophilia and abnormal leucocytes as well as basophile cells analogous to those found in the marrow of bones.—*La Semaine Médicale*, No. 7, 1899.

Frank H. Pritchard M.D.

THE CLINICAL CHARACTERISTICS OF PLEURAL SARCOMA.—Dr. Israel Rosenthal, of Copenhagen, in a paper read before the Medical Society of that city, reports two interesting cases of sarcoma of the pleura. The first was that of a coachman, hitherto well and not hereditarily predisposed, who, after a kick in the chest from a horse, was seized with an affection of an entirely *acute character*—fever, pain in the side, cough, dyspnœa. After being ill for four weeks, the patient entered the hospital with a temperature of 39°, greatly dyspnœic, and with all the signs of an enormous pleural exudate, with great displacement of organs, and diffuse enlargement of the side. There were no mediastinal symptoms, no glandular enlargements, or any other, except the mentioned ones of a tumor in the chest. A series of aspiratory punctures which were vitally necessary were partly negative, partly yielding only a little bloody fluid, which was in great contrast to the size of the exudate; microscopically only blood corpuscles were found. With increasing dyspnœa, after ten days in the hospital, the patient died, the disease *having lasted only between five and six weeks*. The necropsy revealed not the expected pleural exudate, but an enormous soft sarcoma—a round-celled one—while the lung was pushed backwards and atelectatic; the mediastinal glands and all other organs were normal, so that the primary origin of the tumor was certain. The acute febrile course was peculiar, which would rather lead one to think of tuberculosis than a malignant growth. *Stethoscopically*, it resembled a simple pleurisy in every way.

The second case was that of a tailor of 67 years. Here the course was

chronic, afebrile, the disease lasting about a year and a half. There were nearly no chest symptoms, there being chiefly attacks of pain which radiated from the left costal curvature into the left flank and down into the left iliac fossa; there were associated constipation and flatulency. Discharge of flatus relieved the pain. On entering, the cachectic patient who came with a diagnosis of renal colic, of which, beyond the pains, there were not the least sign, presented a left sided moderately large pleuritic exudate, with prominence of the back of the chest. It remained unchangingly thus during the whole course of the disease. Trial puncture yielded nothing or at best a sanguinolent fluid. On the outside of the left portion of the thorax, below and out from the nipple, there was a hard and very indolent glandular tumor of the size of a nut; the overlying integument was normal. No other glandular enlargements were noted and this one remained unchanged. Beyond some increased tympany the abdomen revealed nothing abnormal and particularly, no tumors nor sensitiveness. There was neither mucus nor blood in the stools nor gastric symptoms. The temperature remained normal and the painful seizures prevailed so that narcotics became necessary. Now and then there was pain in the left side of the chest; the bowels continued constipated. The cachexia progressed with oedema about the ankles towards the last. The diagnosis was a slight stenosing cancer of the colon with a secondary carcinomatous pleuritis. The necropsy revealed a tumor of the size of a man's head above the diaphragm in the left pleura. It had compressed the otherwise intact lung downwards and forwards and insinuated itself in between the lung and the wall of the chest. Surrounding the compressed lung was a hæmorrhagic exudate of about eight hundred grammes. The mediastinal glands were sarcomatously degenerated (secondarily). In the right apex a secondary sarcomatous node was visible. In the abdomen there was an incomplete volvulus of the sigmoid flexure.

Diagnostically, the presence of a very hard, wooden hardness, of a supraclavicular or even of an axillary, contraction of the thorax on the affected side with narrower intercostal spaces and increased resistance to the exploring needle are of importance, though the latter symptoms given from Purjez are inconstant and not characteristic of tumors alone. The absence of respiration is also not a wholly pathognomic sign, for in his second case there was wheezing, bronchical respiration right over the place where the tumor lay. Negative puncture is of greater value though not absolutely so. The sanguinolent exudate may be found in tuberculosis or without a tumor being present. The microscopic examination of the exudate is also uncertain. *The greater the number of signs and symptoms, the more certain would the diagnosis be.*—*Hospitaltidende*, No. 12, 1900. (Some time ago one of the best diagnoses that I ever saw was made by a friend of mine, Dr. F. Burt, of Norwalk, Ohio. The patient, a robust farmer of some forty-five or eight years, had been suffering from a seeming intercostal neuralgia for several weeks, and with associated symptoms pointing towards a spinal distrophy. Later unilateral herpes zoster, an enormous plural transudate, with downward displacement of the liver, progressive failure of strength, the appearance of a very hard gland in the supraclavicular space led to and confirmed the diagnosis. At the necropsy the right side of the chest was found filled with liquid while the lung was contracted and carnified into a small mass at the root. The growth extended above the clavicle, and backwards into and infiltrating the muscles of

the back. For a long time the intercostal pains were the only noticeable symptoms).

Frank H. Pritchard, M.D.

FORMALIN AS AN ANTISEPTIC IN GENERAL SURGERY, GYNÆCOLOGY AND OBSTETRICS.—Crawford (Cedar Rapids) has found formalin the most satisfactory antiseptic of any yet known, and has used it with universal good results in all varieties of cases where an antiseptic agent is required. "Its germicidal potency ranks with that of two or three most efficient bactericides, and its inhibiting power is probably greater and more lasting than that of any of them. It is not only an antiseptic, but a deodorizer as well—and solutions of potent strength are much less irritating, both to hands and to wounds, than any other equally efficient antiseptic of which I have any knowledge. It is not injurious to instruments, and, most important of all, it is practically innocuous. Large cavities can be freely irrigated, even the peritoneal cavity, and a considerable quantity of the solution can be allowed to remain without injury or danger of toxic effect. A solution strong enough to completely inhibit the development of pus germs may be used to cleanse, wash out and pack pus cavities and sinuses without interfering in the slightest degree with healthy granulation processes."

A stock solution is made by using an ounce of formalin to a pint and a half of sterilized water, or five ounces to seven and a half pints. One ounce of this mixture, added to fifteen ounces of water, gives the one-fourth of one per cent. solution commonly used for irrigating wounds and moistening dressings. A half per cent. solution is used for disinfecting the hands and the field of operation. The one-fourth per cent. solution equals a 1 to 1000 solution of formaldehyde, the half per cent. a 1 to 500, etc.

In gynæcological practice the author uses a fourth per cent. solution in the vagina and for irrigating the uterine cavity. Simple and specific vaginitis and cervicitis are treated by injections of a fourth or a half per cent. solution. In pelvic abscess, pyosalpinx, appendicitis, where purulent matter has escaped into the general peritoneal cavity, it may be freely irrigated with a fourth or an eighth solution of formalin in normal salt solution, and a pint or two allowed to remain. An eighth or a fourth per cent. solution can be used as a douche after delivery, when one is needed.—*New York Medical Journal*, June, 1900.

Gustave A. Van Lennep, M.D.

INTESTINAL OBSTRUCTION DUE TO PERSISTENT MECKEL'S DIVERTICULUM; SUCCESSFUL LAPAROTOMY.—Fawcett and Jowers (England) report a case of intestinal obstruction due to a persistent Meckel's diverticulum. The patient was a girl, 11 years of age, who suffered with all the symptoms of obstruction of the bowels for four days. On opening the abdomen a quantity of serous fluid escaped, greatly distended small intestines bulged into the wound. The obstruction was found to be due to a nipping of the gut by a thin cord which came from the extremity of a Meckel's diverticulum, which was again attached to bowel, forming a ring through which the strangulated coils had slipped. As it was impossible to reduce the bowel, in its distended condition, the constriction was relieved by cutting off the extreme tip of the diverticulum with scissors, making a small opening into the gut through which gas and liquid faecal matter escaped. This freed the strangulated bowel. The open-

ing was then closed by a double row of Lembert sutures, and the operation finished in the usual manner, the belly being drained for twenty hours by means of a tube. Recovery was uninterrupted.—*The Lancet*, June, 1900.

Gustave A. Van Lennep, M.D.

A BRIEF REPORT OF 108 CASES IN WHICH FOREIGN BODIES (ARTERY FORCEPS, SPONGES, ETC.) WERE LEFT IN THE ABDOMINAL CAVITY AFTER LAPAROTOMY. (Neugebauer.)—The above list is a comprehensive collection from the literature on the subject, but is not complete. It is surprising to note how many times this accident has happened to the most experienced, operators, and it is fair to assume there are many cases not reported, especially by operators of small experience. Fifty-nine out of one hundred and one cases recovered. In cases fully reported there were the following articles:

In 30 cases, a sponge.

In 28 cases, a gauze towel, napkin or compress.

In 4 cases, a drainage tube.

In 1 case, a Richelot's clamp.

In 19 cases, artery forceps.

In 1 case, a seal ring.

In 1 case, a glass irrigation tube.

In 17 cases, article not reported.

The results in the nineteen cases in which artery forceps were left in the abdomen were as follows: There were seven deaths, six soon after from sepsis, and another from injury to an artery after a second operation several months later. Three times the artery forceps were discharged spontaneously per anum, one case after four years, one after nine months, and in the third case after ten months. The artery forceps in another case entered the urinary bladder. Twice the artery forceps escaped through an abscess in the abdominal wall. In one case the forceps were missed before closing the abdomen and found in the *cul de-sac* of Douglas. Twice the abdominal wound was opened after closure and the forceps found. Four times a new abdominal section was performed from 3½ months to two years.

The results of leaving a sponge in twenty-nine cases were as follows:

In nineteen cases the sponge was discovered at the autopsy. Twice the sponge was missed before the wound was closed, and then found.

Three times the abdomen was opened at once and the sponges removed. Three times a new laparotomy was performed, twice after 24 hours and once after 4 days. Once the sponge escaped from an abscess in the abdominal wall after 5 months and 18 days. One sponge was gradually discharged from a fistula in the abdominal wall, after more than a year and a half.

The results of leaving a drainage tube were the following:

In one case it was removed on the fourth day by laparotomy. In another case it dropped out of the vagina while dancing, a long time after the operation.

A drainage tube, introduced after paracentesis of the abdominal cavity, was found at the autopsy two years later in the *cul-de-sac* of Douglas. In one case the drainage tube was expelled by the rectum in two weeks.

The results of leaving in gauze, sponges, napkins and large compresses in thirty-one cases were as follows:

Seven times the gauze pads were found at the autopsy. Ten times they

were discharged spontaneously per anum, with or without symptoms of illeus and in from eight months to twelve years. Four times a gauze napkin or towels were spontaneously removed through an abscess in the abdominal wall. Four times the gauze compress was removed from a mass of inflamed, adherent and injured intestine. Once a gauze towel escaped spontaneously from the prevesical space twenty-one days after a symphyseotomy. Once the tampon fell out of the vagina seven weeks after the operation. Twice the gauze has been kept in the abdominal cavity to suppurate out, and once more when the operator touched it behind the bladder eight weeks after the operation.—*Monatsschrift für Geburtshilfe und Gynäkologie*, April, 1900.

George R. Southwick, M.D.

ECHINOCOCCUS CYST IN THE PELVIS. (Graupner.)—The writer reports a case in which an echinococcus cyst had been enucleated seven and a half years previously from the left broad ligament by laparotomy. It recurred as a cyst the size of a fist on the left side of and anterior to the uterus, which pressed down into the vaginal vault. The character of the growth was suspected from the history, and a positive diagnosis was made by exploratory aspiration and finding the hooklets in the fluid removed. The vaginal vault was incised longitudinally with the Paquelin cautery till a segment of the tumor appeared. The wall of the cyst was then opened with the cautery and a quantity of clear fluid escaped, with typical echinococcus cysts. A portion of the sack-wall was removed by traction and the remainder sewn to the vaginal incision to prevent infection of the wound and consequent recurrence. The prevention of such wound infection was the reason for the vaginal operation in preference to the abdominal operation, and for the use of the cautery instead of the knife. The peritoneal cavity was not opened. The remainder of the cyst cavity was packed with iodoform gauze, which was renewed every two or three days. The cavity contracted rapidly and disappeared in 18 days. *Centralblatt für Gynäkologie*, No. 16, 1900.

George R. Southwick, M.D.

ÆÖINE AS A LOCAL ANÆSTHETIC IN SUB-CONJUNCTIVAL INJECTIONS.—The writer begins his paper with a brief allusion to the value of sub-conjunctival injections of mercuric salts, but remarks that the subsequent pain, even when cocaine or holocain was employed, furnished a great and valid objection to the process, and rendered many practitioners justifiably unwilling to have recourse to it as long as a good result could be expected from the use of milder means.

He believes that æöine removes this objection. In the number of *La Clinique Ophthalmologique* of June 25th last, D. Darien, one of the editors of the journal, published the first account which I had seen of a new preparation called æöine, which he declared to be a non-poisonous local anæsthetic having a very prolonged action; and he described several cases in which its use had rendered the sub-conjunctival injection of cyanuret of mercury painless.

This statement seemed to me to be so important and the effect so valuable that I obtained a supply of the preparation, and my trials of it completely confirm Dr. Darien's assertion. After injecting a mixture of equal parts of a solution of cyanuret of mercury of the strength of 1 in 1000, and of a solution of æöine of 1 in 100, no pain has been produced even when the injection has been a large one, and has been followed by considerable chemosis, and

even by swelling of the lids. Following the example of Dr. Darien, the solvent for both preparations was sterile normal saline solution.

The conjunctiva was cocaineized for the puncture, and the injection was made under the strictest precautions for the avoidance of sepsis. The only complaint made has been a sense of weight and inconvenience from the swelling, which, of course, passed away in the course of a very short time.

Æoine is a white crystalline powder, soluble in water to the extent of 6 parts in 100. The solution keeps well in the dark and is strongly antiseptic. I am content to know that it promises greatly to facilitate the treatment of some of the more intractable inflammatory infections of the eye, and that it takes away the only serious objection to the employment of a method which, in properly selected cases, appears to me to be of great and incontestable value.—Rober B. Carter, F.R.C.S., London, Eng. (*The Lancet*).

William Spencer, M.D.

A FATAL OTITIC ABSCESS IN THE LEFT TEMPORAL LOBE OF THE BRAIN, CAUSING WORD-BLINDNESS.—Operation—Autopsy.—A child, aged 12, had left-sided otorrhœa off and on since childhood. For the past eighteen months discharge has been continuous. Four weeks previous to coming under the author's observation she had an attack of intense frontal headache with nausea and vomiting. Unconsciousness suddenly came on and she had violent convulsions for six hours. Upon examination the patient was found excited, but rational. Temperature 101° F. Eyes normal. Scant secretions from the ear; no sagging of the posterior upper wall; no granulations; slight swelling and tenderness over the mastoid. Optical amnesic aphasia pronounced. When she was asked the name of an object held before her, she said, "I know what it is, but cannot name it;" when told, she instantly and correctly repeated the word.

The diagnosis was made: deep mastoid epitympanic caries, epidural and cerebral abscesses, beginning meningitis.

Upon examination the antrum was found packed with cholesteatomatous masses. The posterior cranial fossa was exposed, but the dura and sigmoid sinus showed no abnormality.

The upper wall of the attic was found carious, and was removed. The dura was congested, slightly uneven and dull. Near the posterior medial corner was a blackish round spot in the dura, with a central depression through which a probe was passed 4-5 c.m. into the brain without any resistance or bringing forth pus or blood. The wound was dressed and patient put to bed. For two days the child was much improved, was cheerful and named most objects at sight. Then she began to complain greatly of headache, temperature rose, pulse slow, and it was decided to again operate, but death suddenly supervened. On autopsy the dura showed dark venous congestion, a few adhesions of dura to anterior surface of petrous bone, some also to the occipital lobe. An abscess cavity occupied the middle of the temporo-sphenoidal lobe. It was surrounded by a dense, uniform white capsule. It was perforated in two places in front, the contents being mixed with the broken-down surrounding tissue and at the posterior medial wall into the posterior outer cornu, the contents filling the lateral and third ventricles and mixing with the softened cortex of the adjacent posterior part of the temporo-sphenoidal lobe.—Herman Knapp, M.D., New York—*Archives of Otolology*.

Wm. Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

ACONITE IN HEART PAIN.—Fornias states that he has prescribed aconite with decided benefit in uncomplicated neuralgia of the cardiac plexus (pseudo-angina pectoris), especially when the retrosternal pain and radiations down the left arm and fingers have been associated with great agony and fear of impending death. In one case which appeared at the height of an attack of acute articular rheumatism, and in another occurring after suppression of the menses from fright, it proved especially helpful. It is equally efficacious in rheumatic pericarditis, when the pain is agonizing, as in *angor pectoris*; and in rheumatic endocarditis, when the cardiac excitement is great, it may prove serviceable. Moreover, there is no doubt of its utility in uncomplicated hypertrophy of the heart.—*N. A. J. of Hom.*, June, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF TYPHOID FEVER.—Halbert, of Chicago, advocates an absolute milk diet unless contra-indications exist. He gives from one to four ounces, always sterilized and diluted with sterilized water, every two to three hours. When the stomach rejects it or seems to tire of it he dilutes it even more or adds lime-water. Barley water, buttermilk, matzoon or koumiss may be substituted for a few days. Beef broth has proven useful when there is extreme anæmia and persistent subnormal morning temperature. When there is extreme delirium and subsultus, and especially when the heart becomes weak, whiskey is added to the milk. Thirst should be fully gratified with sterilized water.

He does not regard the Brand system or its modifications as necessary; if a bath is to be given, he prefers it hot (100° to 120°). Systematic sponging with tepid water and alcohol, ten minutes three times in an hour with ten-minute intervals for rest, and given every two hours or oftener when the temperature is high, will suffice. The high enema of normal saline solution (100° to 115°) is one of the best aids to treatment, and unless there are positive fears of perforation he directs its use with a colon tube every morning. When there is high temperature and delirium it is repeated every hour or two until relief is secured.

The utility of internal antiseptics is questionable, but without doubt some benefit is derived, and he frequently resorts to this method. Boracic acid, in five- to ten-grain doses three times a day, has seemed best. Benzozol, beta-naphthol and salol have their advocates; and the writer ventures the suggestion that methylene blue will yet be found useful. As to stimulants, the indications for the use of whiskey have already been noted, and strychnia is a helpmeet which we cannot discard.

As to remedies, he still holds to baptisia as the standard-bearer; it conforms to the average symptoms of typhoid, and particularly in the early stages. The lassitude, the coated tongue, the absence of appetite, the aggravation from exertion and the quantitative thirst from bryonia; the muscular pains and nervous exhaustion, the tendency to chills, the trembling of the hands and limbs, and the absence of thirst in gelsemium; the dry and red-tipped tongue and the extreme restlessness of *rhux. tox.*; the depression with anxiety, the anæmic appearance, the thirst for water, which cannot be endured, the watery and offensive diarrhoea of arsenic; the subsultus and involuntary stools of hyoscyamus or hyosine hydrobromate; the wild and furious delirium of belladonna; the tympanites and scanty urine of terebinth.; the anasarca or œdema of apis; the debilitated condition and the rumbling of intestinal gases in *carbo veg.*; the vital depression, the bloody stools and the bloody urine of muriatic acid; the sleepy dullness of opium; the active hæmorrhage of nitric acid, and a host of other indicative symptoms call to the mind of every practitioner an experience which shows the efficacy of our treatment.

In conclusion, Dr. Halbert urges the necessity for an accurate diagnosis as a prelude to the management of this disease in which diet is so important, and states that nothing has given him greater satisfaction than the test for Vidal's reaction.—*Clinique*, June 15, 1900.

F. Mortimer Lawrence, M.D.

THE ACTION OF CHELIDONIUM ON THE LIVER.—Neatby has made a careful study of chelidonium, based upon the provings recorded in the "Cyclopædia of Drug Pathogenesis." Peculiar importance attaches to the action of the drug on the liver. We find the region of that organ painful to pressure, with spasmodic pain in the liver all day, and pricking in that region. But by far the most interesting circumstance connected with the liver is that in three different provings the skin assumed a jaundiced hue.

1. Remarkably yellow tinge of the face, especially on the forehead, nose and cheeks. Looked in the face like a jaundiced person, white of eye being dingy yellow; red of cheeks had dark tinge from mixture of yellow.

2. Yellowness of complexion of face, neck and breast, continuing for upwards of eight days. White of eyes became a dirty yellow color, and the edges of the lids were much inflamed.

Again, in another experiment by the same prover: Yellowness about face, whites of eyes and hand, with scintillations before eyes which rendered vision uncertain.

3. Greyish-yellow complexion, so that the prover's unhealthy appearance strikes everyone; hands also become yellow.

Farrington recommends chelidonium in biliousness and in hepatic congestion or inflammation. In the "British Journal of Homœopathy" some interesting cases of gallstones have been said to be cured by chelidonium, as well as cases of jaundice, and one in particular of acute hepatitis.—*Monthly Hom. Review*, July 2, 1900.

F. Mortimer Lawrence, M.D.

MALANDRINUM AS A PROPHYLACTIC AND A REMEDY IN THE TREATMENT OF SMALLPOX.—*The Homœopathic Recorder* gives the following proving as written by Dr. Straube. The provings were made in 1881 and 1883, and with the 30th potency:

Head, Inner.—Frontal and occipital headache. Dullness. Dizziness.

Head, Outer.—Impetigo covering head from crown to neck and extending behind the ears. Thick, greenish crusts with pale, reddish scabs, itching worse in the evening.

Eyes.—Red stripes under the eyes.

Ears.—Profuse, purulent, greenish-yellow discharge, mixed with blood.

Tongue.—Coated yellow, with red streak down the middle (typhoid), also cracked and ulcerating down the centre. Tongue swollen.

Stomach.—Vomiting of bilious matter; nausea.

Abdomen.—Pains around the umbilicus.

Stool.—Dark, cadaverous-smelling. Yellowish, foul-smelling diarrhœa.

Sexual Organs, Females.—Vagina closed with impetiginous crusts. Yellowish-greenish-brown in color.

Back.—Pain along back, as if beaten.

Upper Limbs.—Impetiginous crusts on the extensor sides of forearms.

Lower Limbs.—Pains, especially in the left tibia, with petechiæ-like patches on anterior aspect of left leg from knee to ankle. Petechiæ on both thighs, worse on left.

All the Limbs.—Sore pains in limbs and joints. Run-arounds on the nails of hands and feet.

Time.—Worse in evening.

Skin.—*Smallpox, measles*; also as preventive. Impetigo covering back of head, extending over the back to buttock, and even into the vagina; covering the labiæ. Impetigo on extensor of forearms. Boils. Malignant pustule. Bad effects of vaccination. Small, dusky red spots on legs, not disappearing on pressure. (Typhoid fever. Petechial typhus.)

W. D. Carter, M.D.

CALCAREA PHOS. IN CHRONIC PLEURISY.—Hallock, Saranac Lake, N. Y., says the remedy is indicated where there is little or no fever, and the pains will not be of the sharp character which accompany acute pleurisy, but more sore pain, "a hurt with every breath-cough," usually worse at night, disturbing sleep.

These pains are brought on by sudden changes in the weather, damp weather; also by severe exercise.—*Homœopathic Recorder*.

W. D. Carter, M.D.

DISEASES OF THE BREAST AND NIPPLES DURING THE PUERPERIUM.—Reynolds, Grand Haven, Mich., finds his indications for a remedy to combat the above conditions, thus:

Phytolacca 6x. Entire indifference to life and disgust to the affairs of the day; breast painful and very much engorged; pain goes from the nipple all over the body; the drawing of the milk is impossible, and later on the breast may assume a purplish hue.

Bryonia 6x. Lowness of spirits; fears, apprehensions, anxiety, desires for things which do not exist, or which no longer cared for when offered; breast is hot, painful and hard, a sick feeling when moving about or sitting up, thirst for large quantities of water, constipation, lips rough and dry.

Belladonna 6x. Frequent moaning without knowing why, uneasiness, she changes from one place to another, irritable moods, breasts swollen, glossy, hard and heavy, severe sticking and tearing pain, throbbing of breast, red streaks running from a central point, fever with starting sleep.

Hepar Sulph. 6x. Hypochondriac; sad mood for hours, the slightest cause irritates her, dejected, especially in the evening, breasts tend to suppuration, or after suppuration has begun, with scanty discharge; women with unhealthy skin, burning and throbbing in breast, especially at night.—*Medical Counselor*, June, 1900.

W. D. Carter, M.D.

THLASPI BURSA PASTORIS.—Dr. Johnson, Sherman, Texas, says: One month ago I prescribed this remedy, in the 2d centesimal potency, for a lady patient 48 years of age. Hysterical in the extreme. Always complaining, symptoms always changing; seemed delighted at the slightest chance to complain. Menses had always been regular until recently they became profuse, protracted, lasting twelve days. Uterine cramps, leucorrhœa profuse, constantly changing in appearance, but always acrid, inflaming all parts with which it came in contact. Urine rather scant, containing considerable quantities of brick-dust looking sediment. All symptoms seemed better after one week, but most remarkable was a discharge of tapeworm during the second week, more than 80 feet passing.—*Homœopathic Recorder*.

W. D. Carter, M.D.

MALARIA AS A REMEDY.—A preparation of swamp vegetation which is allowed to decompose at a high temperature, and termed malaria off., is used by Bowen, Ft. Wayne, Ind., for chronic rheumatic troubles in every phase. A case of troublesome gout came under his care. The patient aged 60 years, and weighing 200 pounds. Pains in her feet distressing, and unable to move herself without aid. Malaria 2 c.c. No. 30, pills every two hours for twelve hours was administered, with the result that she could walk with a cane. In forty-eight hours she could walk without help. The remedy was continued for a week, with the doses at further intervals, and no pains came back; but it was noticed that she was languid, dull and much more sleepy than ever before. It did not interfere with the digestion, kidneys or the bowels in any way.—*Homœopathic Recorder*.

W. D. Carter, M.D.

ON A LITTLE KNOWN METHOD OF TREATMENT OF FURUNCULOSIS.—Langmann recommends the use of the galvanic current for the treatment of boils, both as an "abortive" measure and to hasten healing after suppuration has been established.

The method of procedure is as follows: "The cathode-pole is placed upon the furuncle, the anode somewhere in the neighborhood, and a current of about two to five milliampères is applied for from five to ten minutes. As a rule, one sitting daily is sufficient. The intensity of the current ought to vary, both with the stage of development of the boil (the earlier stages being more sensitive) and with individual sensitiveness. The feeling of a lively sting entering, as it were, the centre of the boil, just enough to be tolerated, indicates about the proper strength of the current.

With this treatment it is hard to say whether the natural duration of a boil is shortened, as they differ in their course. When extensive suppuration is present a pledget of cotton soaked in a 1-1000 sublimate solution is placed between the sponge and the skin.—*New York Medical Journal*, June, 1900.

Gustave A. Van Lennep, M.D.

THE HAHNEMANNIAN MONTHLY.

OCTOBER, 1900.

THE RELATION OF SYPHILIS TO DISEASES OF THE NERVOUS SYSTEM.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

(Read before the American Institute of Homœopathy, June 20, 1900.)

THE vastness of the pathological and clinical knowledge concerning syphilis of the nervous system makes it impossible for the writer to give anything like a complete review of the subject in the few minutes assigned him for that purpose. He will, therefore, confine himself to a presentation of such facts and opinions as seem to be of most interest to the members of this section.

There can be no doubt of the fact that syphilis of the nervous system is by no means uncommon; and yet it is astonishing to note the large number of physicians who state that they have never seen a case. This to the writer is strong presumptive evidence that many cases have failed of recognition. That diagnostic errors should be frequent is quite natural when the nature of the question is looked into. The fact that syphilis is, with few exceptions, the result of immorality, leads patients to deny its existence even to their physicians. Again, syphilis is sometimes contracted through innocent channels, and its victims are not cognizant of the nature of their complaint; and in still other instances the initial sore, though contracted in illicit intercourse, may be situated where it escapes recognition. Then we have facing us the additional fact that in the majority of cases of syphilis of the nervous system the so-called

secondary manifestations have been mild,—so mild, indeed, as to escape recognition. That patients may give incorrect histories respecting a syphilitic infection, I may instance the following cases:

Mrs. W., æt. 26 years, had Jacksonian epilepsy, double optic neuritis, and severe headaches, worse at night. She was cured by iodide of potassium. Her children had Hutchinson teeth. Her husband had Argyll-Robertson pupils, absent knee-jerks and lightning pains and static ataxia. Yet syphilis was denied by both husband and wife.

Mr. Y. and his wife both had locomotor ataxia. She was very much benefited by anti-syphilitic treatment. He was indignant at the suspicion of syphilitic infection, and forced his wife to abandon the treatment. She then relapsed, and finally became helpless.

Mrs. Z., æt. 30 years, was taken suddenly with nerve deafness; her husband denied syphilis. Later he manifested all the typical symptoms of general paralysis of the insane.

Mrs. A., colored, sustained an injury alighting from a street car. The following week she became hemiplegic. This hemiplegia progressed slowly. About one year after the accident the other side became involved. It was then that I assumed charge of the case. She had ocular palsies, double optic neuritis, and nocturnal headaches. She had been in a prominent old-school hospital for the year preceding. Anti-syphilitic treatment caused the recent paralysis to disappear within three weeks, while improving the power on the side first affected. In this case the injury, occurring prior to the onset of the symptoms, led to an erroneous conception of the nature of the case.

Such instances as the above might be narrated without end. These few serve to demonstrate the possibility of getting incorrect histories. What has happened once may readily happen again.

It must also be remembered that seeing many of our patients in their best days, when maturity has taught them the follies of youth, we are apt to forget the possibilities of early vice, and fail to make the important inquiry after syphilitic infection. This I know from sad experience. Many have been the times, in consultation cases, I have inquired of the family physi-

cian as to the possibility of syphilis, and have been met with the reply, "O, no, doctor; he is not that kind of a man," and then I have taken the opportunity of investigating for myself, and have received affirmative information. It should be remembered that the man need not have been very bad; he may have sinned or acted the part of fool but the once, which, under favorable circumstances, is all-sufficient.

Fortunately, in very many instances, the failure to obtain a specific history matters but little, because of the characteristic features of the illness. I say fortunately, because an early diagnosis is of the highest importance, for syphilis of the nervous system, when recognized early and treated properly, gives results that in the majority of cases are very satisfactory. If neglected, secondary changes take place in adjacent portions of the nervous system, and the case becomes incurable.

Of the conditions which I would especially emphasize as always syphilitic in origin, locomotor ataxia stands pre-eminent. In 90 per cent. of my cases, and I have seen not less than 300, a history of syphilis has been obtained. As to the other 10 per cent., is it not remarkable that there is that small percentage of mendacity or ignorance among syphilitic subjects? The failure of anti-syphilitic medication to cure ataxia does not invalidate its specific origin, for this, as well as certain other affections, is now recognized as a para-syphilitic disorder in which the toxins have produced degenerative changes.

Among the data upon which one should rely for the diagnosis of syphilis of the nervous system age is exceedingly important. The vast majority of non-specific diseases of the nervous system, if we except such important clinical types as acute poliomyelitis, Friedreich's ataxia, progressive muscular atrophy, epilepsy, etc., occur during the degenerative period of life, *i.e.*, after the fortieth or fiftieth year. Syphilitic affections occur with especial frequency among young adults. Indeed, it might be stated as an aphorism that 80 per cent. of all cases of organic diseases of the nervous system occurring before middle life are syphilitic in origin. The remaining 20 per cent. include cases of abscess of the brain, embolism, the degenerative changes attendant upon renal disease, traumatism and malignant growths.

Of the special symptoms suggestive of cerebral syphilis,

headache is one of the most prominent—prominent because of the regularity with which the meninges are involved in the pathological process. This headache is generally one of the earliest symptoms, and is usually associated with sensitiveness of the scalp, and is aggravated at night.

Syphilitic hemiplegias are nearly always dependent upon vascular disease—a syphilitic endarteritis. This leads to one of two conditions: rupture, with extravasation of blood, or obstruction, with the consequent softening. Symptomatically, these hemiplegias differ in no particular from those originating in the vascular diseases of advancing years and renal disease, for in each case the same mechanical phenomena are the function-disturbing factors. They are noteworthy, however, because of their multiplicity, their frequent association with aphasia, and a prodromal period. Aside from vascular changes, syphilis may produce hemiplegia through the agency of gummatous growths, meningitis, and connective-tissue hyperplasia. Very characteristic of syphilis are those cases in which the illness presents hemiplegic seizures of short duration.

Paralyses of cranial nerves constitute a very important manifestation of cerebral syphilis. So characteristic are these palsies of the condition in question that I have long held that cerebral symptoms, associated with ocular palsies occurring in young adults, are so certainly due to syphilis that the most strenuous denials of a specific infection would not alter my opinion concerning the nature of the case. Indeed I would ask such patients, not "Have you had syphilis?" but "When did you contract syphilis?" Jonathan Hutchinson has taken such an extreme view of the origin of motor oculi palsies in general, and of paralysis of the levator palpebræ superioris in particular, that he has spoken of them as "the signature of syphilis upon the face."

The ocular nerves are not, however, the only ones invaded by the syphilitic process, for I have seen several cases in which the functions of all the cranial nerves from the first to the eighth, inclusive, were seriously disturbed.

The relation of syphilis to the production of insanity does not seem to have been sufficiently recognized by those who have had the best opportunities of observing insane patients. Thus I note, in the recent report of a skilfully conducted

asylum, that of 1865 patients, in but 38, or a little more than 2 per cent., was syphilis the cause of the mental disorder. Think of that! The percentage of syphilis in the insane 2 per cent., while that of the community at large in great cities is 5 per cent. Were such figures correct, syphilis would appear to be a preventive of insanity. My work has placed me in somewhat close relations with the asylum referred to. There have been cases admitted to it in which syphilitic infection was unknown to the superintendent and was known to me. Asylum superintendents fail to obtain a syphilitic history because the mental condition of their patients makes the obtaining of a correct history impossible. Friends and relatives cannot give the needed information, and charitably assume the disorder to be due to overwork, grief, and like causes.

While the majority of cases of acute mania, melancholia, etc., are due to purely nervous causes, there is undoubtedly a respectable percentage in which the constitutional infection has made the exciting causes operative, and without infection the insanity would not have occurred. General paralysis of the insane is undoubtedly the form of insanity which, above all others, is produced by syphilis. The majority of alienists admit the frequency with which it occurs in syphilitic subjects. None admit its universal dependence upon syphilitic infection. Personally I might say that all of my cases, with the exception of one, have admitted a specific infection; and in that one, as already stated, the patient's wife suffered from a cranial nerve affection which, to say the least, was suspicious. In the above remarks concerning syphilis and insanity I except, of course, those cases of delirium and mania in patients with syphilitic meningitis in which the nature of the case is admitted by all.

The relation of hereditary syphilis to nervous diseases is still an open question. The opinion that they are not uncommon is more prevalent than it was ten years ago. There is a growing conviction that many cases of epilepsy are due to this cause, and it has been demonstrated pathologically that endarteritis, gummatous growths and connective-tissue hyperplasias may occur in the hereditary as in the acquired form of the disease. This being the case, there is every reason to assume that syphilitic disease of the nervous system should be frequent in childhood, though not by any means as frequent as in adult

life, because hereditary syphilis is not very common, not only because of the actually smaller number of cases, but because of the early deaths of the little sufferers. It would be a very interesting investigation that would determine the subsequent clinical careers of those who survive, living on to late adult life. I believe that were such an investigation started it would yield interesting results, for, notwithstanding the excellent results attendant upon anti-syphilitic treatment, very few cases of syphilis are cured, or indeed are curable. The poison remains in the blood, and carries on its ravages until the end of time as measured by the human life.

THE GENERAL CONSIDERATION OF ACUTE PERITONITIS.

BY W. E. GREEN, M.D., LITTLE ROCK, ARK.

(Read before the Surgical and Gynæcological Association of the American Institute of Homœopathy, Washington, D. C., June 18, 1900.)

EVERY trauma of the peritonæum is followed by a certain degree of inflammation that, unless infection occurs, is circumscribed and limited in its tendencies to extension. As in injuries to other structures of the body, there is a strong disposition to spontaneous recovery. The process causes plastic exudations from the serous surfaces, with consequent visceral adhesions, and is attended with febrile reaction and localized pain and soreness. Since every intra-abdominal operation more or less involves the peritonæum, a very large percentage of the cases of traumatic peritonitis is of surgical origin, and is of special import to the individual operator.

The form of peritonitis that is of most interest to the profession in general, and to the patient in particular, is essentially a bacterial production, an inflammation caused by germ infection; one in which the specific form of micro-organism present not only stamps the type of disease, but controls the accompanying pathological lesions and dictates to a certain extent the method of treatment. A pure form of germ infection, however, does not always exist; a variety of bacteria may be present; therefore, the disease may be greatly modified in symptoms,

course, and pathological features. The principal pathogenic organisms that superinduce peritonitis may be classified as follows: The bacillus coli commune, streptococcus, staphylococcus, gonococcus, bacillus tuberculosis, and diplococcus pneumoniae.

The coli bacillus is responsible for a large percentage of the cases of peritonitis. This germ is ever present in the intestinal tract, and the avenues for its entrance into the peritoneal cavity are multiple. The inflammation caused by this organism is not usually of a severe type, nor is it attended by high temperature or profound toxæmia. The serous and lymph exudations are slight, and consequently the adhesions are limited and delicate. This form of peritoneal infection gives the largest percentage of recoveries.

While this is true of the coli bacillus, much the opposite obtains in streptococcic invasion. This germ develops a high grade of sepsis that possesses great devitalizing properties. A rapid pulse, 140 to 160, and profound toxæmia, quickly follow infection, and death, usually from heart paralysis, terminates the scene in from a few hours to three or four days. The spread of the disease over the peritoneal surfaces and through the subserous lymphatics is so rapid, the serous exudations so profuse, and the effusion of plastic lymph so limited, that there is but slight, if any, tendency to adhesions or the development of gross lesions, the peritonæum showing no change save that of increased vascularity and softening.

Peritonitis caused by staphylococcic infection has a great tendency to localization. The exudations of both serum and lymph are limited. Circumscribed abscesses form, which are filled with creamy pus and walled off by visceral adhesions. Owing to the limited opportunities for lymphatic absorption of septic matter, the toxæmia is not usually profound, though, after abscesses have formed, a high range of temperature, a moderately rapid pulse, rigors and sweats may persist.

Diffuse general peritonitis caused by gonococcic infection is of rare occurrence, though its existence has been demonstrated. The inflammation caused by this germ is of a plastic nature, with consequent tendencies to localization; therefore under ordinary circumstances it is not attended with diffusions of purulency and its concomitants. In fact the disease has decided benign tendencies. The germs travel by continuity of

tissue, and not through lymphatic currents. An invasion is from the genito-urinary tract, and usually reaches the peritonæum through the Fallopian tubes; the plastic nature of the inflammation generally localizes the disease, confining it to the pelvic cavity. The time of greatest danger of general peritonitis from this source is during the puerperal state and at the menstrual period. While the acute stage of gonorrhœal peritonitis is attended with pain and suffering, the thermal range is not usually high.

Acute peritonitis is sometimes caused by a rapid diffusion of tubercle bacilli in the abdominal cavity. The inflammation causes a rapid effusion of ascitic fluid, or it develops either a fibrino-plastic or an adhesive peritonitis. Suppuration does not occur except through the invasion of other germs.

Pneumococcic infection of the peritonæum causes a suppurative peritonitis, with consequent tendencies to localization.

The avenues through which bacteria may enter the peritoneal cavity are so numerous that it will only be necessary to mention a few of the most important of them. Peritoneal infection may occur from any wound, surgical or otherwise, that penetrates the abdominal cavity. It may come through an extension of inflammation from some of the abdominal or adjacent viscera. It may be caused by a transmission of the coli communis through the walls of inflamed or obstructed intestines. It may be carried from an infected uterus or vagina through lymphatic channels, or by continuity of tissue through the Fallopian tubes. It may take place through perforation of the viscera, as the appendix, gall-bladder, kidney, urinary bladder, intestines and stomach. Other notable sources of infection are from necrosis of tissue, and from abscesses in the different abdominal viscera and adjacent organs breaking and emptying their infected contents into the abdominal cavity, as the liver, spleen and kidney, or the pleura and lungs.

The treatment of peritonitis may be either medical or surgical, or medical and surgical combined, according to the demands of the individual case.

Traumatic peritonitis requires simply rest in bed, the administration of such remedies as aconite, belladonna, bryonia, rhus. tox. and arsenicum; the application of dry heat, and, at times, opiates to assuage excessive pain and suffering.

It is a trite saying that an ounce of prevention is worth more than a pound of cure; therefore every possible prophylactic measure should be instituted to prevent peritoneal infection. Wounds of the peritonæum and abdominal viscera should be managed with scrupulous attention to cleanliness. Intra-abdominal operations of every character should be performed under rigid aseptic precautions, and conducted according to the most recently accepted methods. Abscesses of adjacent organs that threaten the integrity of the peritonæum should be opened early; uterine diseases that are liable to infect the peritonæum either by tubal or lymphatic invasions should receive early and rational attention. In cases where septic endometritis exists, prompt curettement and cleansing should be instituted. In putrid infections of the endometrium and in puerperal endometritis, a thorough cleansing by intra-uterine irrigation with a mild antiseptic solution should be done. This flushing should be performed in a most thorough surgical manner, and repeated every one to six hours, as may seem necessary. After the douching a large iodoform gauze packing should be applied. If twenty-four to thirty-six hours of this treatment does not materially modify the symptoms of sepsis, the surgeon can rest assured that infection has invaded the pelvis, and he should not hesitate to make an opening through the posterior vaginal *cul-de-sac* at once, carefully inspect the viscera, evacuate the accumulated fluid, break up the adhesions and apply adequate drainage.

A large percentage of the cases of peritonitis are caused by appendicitis, and these cases are frequently of a virulent form. Suppuration should be anticipated and peritonitis prevented whenever possible by an early removal of the appendix.

In the first stages of peritonitis, before the disease has been fully established, every effort should be made to abort it. The patient should be kept quiet in bed, food of every kind withheld, the bowels excited to action by the administration of saline cathartics, the use of medicated enemata, and dry heat applied to the abdomen. Internally, such remedies as aconite, belladonna, bryonia, rhus. tox., arsenicum and apis should be given. Many cases of peritonitis will be cut short in the early stages by this course of management, and surprising cures of well-developed ones will sometimes be accomplished.

When the disease has once become fully established, usually nothing more in a curative way can be expected from therapeutic measures, and the physician must turn to surgical methods as the only hope.

The time and method of operating and the location of the incision will depend largely upon the type of infection and character of the lesion. In this, like in many other problems in surgery, the clear judgment of the operator must guide him in his actions. Where the nature of the infection causes plastic exudations and a tendency to localization of the disease (fibrino-plastic peritonitis), prompt surgical interference may not always be demanded; the symptoms and condition must direct the surgeon. When suppuration develops, however, operative procedures should be promptly instituted. The presence of pus in any of the tissues of the body is devastating and delay in operating is to be deprecated, and this is especially true of the peritonæum. An incision should be made at the seat of localization, usually over the greatest prominence, and the abdomen carefully opened. If adhesions have formed to the abdominal walls, the abscess should be incised, the pus evacuated, and proper drainage applied. If it be found that the abdominal cavity is not protected by adequate adhesions, the pus sac should, if possible, be stitched to the parietal peritonæum and the abscess evacuated. If this procedure is not feasible, gauze should be packed in around the opening to induce plastic exudations, and left there for two or three days until adhesions have formed; after which, the sac can be opened with safety.

Acute diffuse peritonitis usually proves fatal in from one to five days; therefore any operations for its relief must be done early, as these cases will not brook delay. A few hours' procrastination may mean the death of the patient; therefore, since nothing can be gained by waiting, the surgeon should promptly open the abdomen by a median incision; this should be made sufficiently large for exploratory purposes. The sero-purulent fluid should then be evacuated, and a careful search made to find the exciting cause of the disease. The intestines should be gently drawn out of the abdomen and cleaned by douching with a hot sterilized saline solution, and, if flocculent deposits of lymph are formed on the surface, wiped with sterilized gauze. As the viscera are delivered, they

should be well protected by enveloping them in towels wrung out of a hot saline solution, temperature 105° . If the bowels are greatly distended, they should be emptied either by stripping or by incision, which is afterward closed by suturing. The cause, if found, should be removed, all adhesions broken up, and the intestines returned, after which a thorough flushing of the abdominal cavity with a hot saline solution is instituted. This should be done by an irrigator placed well down into the bottom of the abdomen and then moved about in every direction among the coils of intestines. Two or three gallons of water should be used in this way, and a quantity may be left in the abdomen. Free drainage should now be applied; a large fold of plain sterilized gauze should be passed down among the coils of intestines, one in either lumbar region and one in the pelvic cavity, leaving one end protruding through the abdominal opening; but little effort should be made to close the incision. It is better and safer to leave it open. If the patient lives, there is time enough to close it; sometimes it will be necessary to make multiple openings to facilitate drainage. In highly infected cases it may be better to introduce alongside of the gauze large drainage-tubes, so that the abdomen can be flushed every hour or two until sterilization is accomplished. My first operation for appendicitis, performed twelve or fourteen years ago, developed a suppurative peritonitis. I went at night, by special train, to a neighboring town, distant 150 miles. When I arrived at 2.30 A.M. I found the patient in a most deplorable condition. The physician had deferred calling me until he demonstrated the existence of pus by hypodermic exploration. He then wanted me quick. The temperature was very high, 105° , pulse rapid, 140, and a high grade of toxæmia existed; the mind was wandering and the speech muttering.

The patient was placed upon the table, the abdomen opened, and the purulent fluid evacuated. With a hand in the abdomen, I found the intestines matted together in every direction; these attachments were broken up, and pocket after pocket of pus evacuated. A thorough flushing was then done by moving the douche-pipe about in every direction. A large drainage-tube was introduced into the right lumbar region and another in the pelvic cavity. I ordered the abdomen flushed every one

to three hours with a saline solution until the septic symptoms abated. The patient recovered, and is well to-day.

In the management of these cases the general treatment is of vast importance. The heart should be sustained by hypodermic administration of strychnine and digitalis. Nourishment may be given by rectum when vomiting is persistent. If nausea is defiant and persistent, lavage should be used every three to four hours. Intravenous injection of normal salt solution should be tried if the heart grows very weak and rapid.

I have on several occasions used the antistreptococcic injection, but, I regret to say, without results; it might be more beneficial if brought into requisition after the abdomen has been cleansed.

THE KLEBS-LÖEFFLER BACILLUS, ITS TOXIN AND ANTITOXIN.

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(Read before the Philadelphia Medical Club, June 6, 1900.)

THE name diphtheria was given to the disease by Bretonneau, who in 1821 published in Paris an extensive and so correct an essay on the malady that little advance in knowledge took place until the recognition of the relation of the diphtheria bacillus and their associated micro-organisms to the disease. The bacillus was first discovered by Klebs in 1883, who found it in the pseudo-membrane obtained from the throat of patients suffering from true diphtheria. The following year (1884) Löffler succeeded in isolating and growing pure cultures of the bacillus, and these when inoculated upon the abraded mucous membrane of susceptible animals produced a more or less characteristic pseudo-membrane, frequently followed by death or paralysis, and accompanied by the characteristic lesions. From the combined discovery the name Klebs-Löffler bacillus. Using the tubercle bacillus for comparison, we find that the Klebs-Löffler bacillus is slightly longer and about twice as thick; like the bacillus tuberculosis it is generally slightly curved, but with rounded ends. Morphologically,

the bacillus is characterized by its irregularity, while in fresh cultures the large majority of these micro-organisms are as described above; but as the culture increases in age the bacillus usually increases in length, and many are found with one end swollen, giving the appearance of a club; others have both ends swollen like a dumb-bell, while yet others are swollen near the centre, with pointed ends.

The Klebs-Löffler bacillus is a non-motile, non-liquefying bacillus, growing best in the presence of oxygen, but also growing without oxygen; it forms no spores, and of all the bacteria it is the most easily destroyed by disinfectants.

The Klebs-Löffler bacillus is present in the pseudo-membrane of all cases of true diphtheria, and when the disease affects the tonsils and upper air-passages, is found throughout the cavity of the mouth. The number of bacteria varies greatly, they lie superficially and rarely or never penetrate below the false membrane, and, so far, they have never been found in the blood of living patients, and only in a few rare cases have they been detected in the blood and viscera of patients dead of diphtheria.

The changes produced by the bacilli are purely local, consisting of a coagulative necrosis of the epithelium and the upper layers of the mucosa, converting them into the so-called diphtheric membrane.

While the true diphtheric inflammation does not exist independent of the Klebs-Löffler bacillus, it is not always the case that the bacilli cause the typical necrotic changes, for the micro-organism has been found in cases of fibrinous rhinitis, and in croupous conjunctivitis, the action here being to produce a croupous exudate without necrosis; and, furthermore, virulent cultures of diphtheria bacilli have been obtained from the mouths of perfectly healthy children, showing that under certain conditions the bacilli may exist on a healthy membrane without occasioning the disease.

The bacilli, then, being responsible for the necrotic or local changes only, we must therefore consider the constitutional manifestations as depending entirely upon the absorption of the toxic product, and class the disease as a *toxic infectious disease*. Experiments upon animals have proven it to be such; for, no matter what may be the virulence of the inoculated culture, the

bacteria remain at the site of inoculation and penetrate the tissues but little, if any. Multiplication of the bacilli is slight, and if so, only during the first few hours following the inoculation; later they diminish, and frequently they disappear entirely, or they may remain alive in the necrotic tissue for several weeks. That the disease is purely toxic is shown: First, by the diminution in the number of the bacilli, or of their complete disappearance; Secondly, by the complete absence of the bacilli in the blood, or in any of the organs or tissues of the body beyond the necrotic membrane; and, Thirdly, by the fact that if an animal be inoculated with the toxin alone there results all the constitutional manifestations, but minus the necrotic changes and formation of the pseudo-membrane.

In the human being the Klebs-Loeffler bacillus is rarely found alone in the disease, but is generally associated with one of the streptococci, staphylococci, or the pneumococcus or coli commune, and it is certain that the severe septic infections occasionally met with in diphtheria are due, not to the Klebs-Loeffler alone, but to a mixed infection, and especially with a virulent streptococci. In proof thereof it has been found experimentally that attenuated non-virulent cultures of diphtheria bacilli can again be rendered virulent by inoculating them together with a virulent culture of streptococci.

The entrance of the micro-organism into the system may take place through any of the mucous membranes, or through an open wound. The most frequent avenue being the mucous membrane of the pharynx, larynx and nose. While in the great majority of cases it is due to direct association with patients affected with diphtheria, a certain number of cases undoubtedly contract the disease through the food, eating- and drinking-utensils, etc. The air as a media probably does not act for any great distance, as the bacteria are very sensitive to both dryness and the action of direct sunlight, and up to the present time the diphtheria bacillus has not been detected in the air.

Children can be, and undoubtedly are, infected from an adult, who at the time of caressing or kissing the child is suffering from a clinically harmless attack of follicular tonsillitis or angina. I have in mind four cases of like infection, two of

which died with septic complications. Again, other sporadic cases occur in which no known source of infection can be traced, as, for example, the first case in a village isolated from all known contagion; and yet at the present time the saprophytic occurrence of the diphtheria bacillus outside the living body has not been demonstrated. Again, it is certain, from observations of virulent diphtheria bacilli taken from the mouths of perfectly healthy children, that a certain predisposition is necessary, such as a lesion of the mucous membrane or the like, in order that a case be infected from a case of true diphtheria.

Diphtheria, then, being a toxic infectious disease, and not, as in the case of the streptococci and staphylococci, an infection due to the multiplication of the bacteria themselves, the only rational mode of treatment, from a bacteriological point of view, is the use of some substance, or substances, that will destroy the action on the tissues of the toxin, and thus cause the soil to become unfit for the growth of the bacilli, and the consequent elimination of the toxin. This substance is contained in the so-called antitoxin, but more correctly speaking the diphtheria antitoxin, for at the present time there are two true antitoxic serums on the market, the diphtheria antitoxin and the tetanus antitoxin.

Probably no discovery in therapeutics has ever caused more discussion, and about which more has been written and said, than about antitoxin. It has its friends and its enemies, and a large intermediate class of undecided ones; these are gradually taking sides according to the method in which they make use of the serum. Why these wide differences of opinion? Is it the fault of a reliable antitoxin? No. Is it the fault of the disease? Only in very rare cases. Is it the fault of the physician and his method of using the serum? Invariably yes. If so, why? Were it possible for a member of each class to use the same bottle of antitoxin on the same case and after his own method, the results would be totally different and their opinions would remain unchanged. And why? In class one are those physicians who use antitoxin scientifically, use it early, and in all suspicious cases of throat trouble they should, and many of them do, make cultures; but they wait not for the bacteriological report, but use the serum immediately. Their results far surpass those of any other known method of treatment.

In class two are those physicians who are as yet undecided as to the merits or demerits of antitoxin; they use it with fear, and with no hope of benefit to be derived therefrom. They use it only after diagnosis is absolutely positive, if culture has been made; and be it said to their credit they as a class make use of the culture method of diagnosis extensively; but they make the great mistake of waiting for a bacteriological report, and all the time the toxin is accumulating and destroying cells beyond repair. Although they are using antitoxin as an experiment, they use it neither scientifically nor in the true spirit of an investigator. Their deductions are that antitoxin has no prior therapeutic claims.

Class three, those physicians who condemn antitoxin at every opportunity, both in season and out of season. From personal knowledge obtained from conversations I have had with members of this class, and from published articles, many of them have never used a bottle of antitoxin in their lives; a group, to speak plainly, of therapeutic fanatics. The remainder of this class have used the serum once, or at most a few times, but, no matter when or how, always improperly, always after other treatment has failed to check disease and the case is rapidly sinking; then as a last hope, and in an endeavor to escape censure, they turn to antitoxin with the only result possible, death of the patient. Is the condemnation of such men of any value whatsoever? I leave you to judge.

But why these various diverse opinions and results? Class one use the serum as it has proven successful in animal experimentation, that is early, not waiting until the disease is well developed. Class two only after the disease has thoroughly manifested itself, and diagnosis is positive. Class three only as a last resort, if at all, after all other treatment has failed, or, as is frequently the case, the family of the patient has insisted upon its use.

The reasons for the different results obtained are plain. Antitoxin is a preventive and not a cure; its action is to prevent the poisonous action of the toxin upon the tissue cells, and so far as is known it has no influence upon the cells after they have been injured by the toxin. It neutralizes the toxin, but has no effect upon the bacteria beyond making the soil unfit for their growth. The diphtheria bacilli grows perfectly well in its antitoxic serum.

Experimentally, a much smaller amount of antitoxin will neutralize a fatal dose of toxin in an animal if given before or with the toxin than if given shortly after; and in an animal already profoundly poisoned by the toxin, no amount of antitoxin will affect it. The same is true of human beings. After the toxin has affected enough of the parenchyma cells of vital organs to cause them to be unable to perform their functions it is perfectly useless to give antitoxin, and still worse to condemn it for such failures. After the house is burned there is little use for a fire extinguisher, be it ever so perfect.

By some (the enemies of antitoxin), the argument used for its condemnation is that it is an unproven drug; in reality it is better proven than any therapeutic agent we have to-day. Every bottle of antitoxin sent out by a reputable firm has been tested on an animal, and the proving is stamped on the bottle in so many units strength per c.c., thus telling exactly how many units of toxin each c.c. will neutralize. Is there any drug in the materia medica so well and frequently proven? While antitoxin is proven at each manufacture, what can be said of our drugs? Many, in fact most of them, were proven years ago, and on persons living under different conditions from now. Is the drug power of a plant the same this year as last? Is not the strength of the plant juice modified by the season, whether hot or cold, wet or dry? And can the recorded symptoms of all provers be taken as true? And does not the idiosyncrasy of the patient modify the drug action? While, on the other hand, the toxin of the Klebs-Loeffler bacillus is always the same, and the unit of strength of the antitoxin is a definite quantity and remains always the same, the prover, an animal, has no chance to falsify or imagine symptoms; the toxin and antitoxin work it out; the unit of strength is the proving.

In conclusion, gentlemen, let me beg of you to use the serum in a scientific manner or use it not at all; better inject ten cases of non-diphtheric sore throat early, than wait and inject too late in a case of true pseudo-membrane. Should you be called to see a case well advanced, use the serum, and use it freely. I believe most of us stop the injections too soon, and that many cases of post-diphtheric paralysis, heart-failure and nephritis would be avoided were injections of one thousand units given

each for three or four days following the disappearance of the membrane.

We all agree that an ounce of prevention is worth a pound of cure; so also is a prophylatic dose of two hundred and fifty units given to a case known to have been exposed to contagion, better than all of the thousand units that can be given after the disease is thoroughly developed. If in using the serum you wait until the diagnosis is positive, and the case is profoundly poisoned, and it then results fatally, do not blame the antitoxin, and condemn it as so many do, but put the blame where it belongs, and that is on yourself. I make bold to claim that no physician who has used antitoxin in a scientific manner has as yet been found to condemn it. As to the mortality rate in diphtheria since the introduction of antitoxin, provided it is used scientifically, I can express it no better than to quote the conclusions arrived at by Briggs and Guerard, who, after a review of all the statistics and opinions published since the beginning of the antitoxin treatment in 1892, say:

“It matters not from what point of view the subject is regarded, if the evidence now at hand is properly weighed, but one conclusion is or can be reached—whether we consider the percentage of mortality from diphtheria and croup in cities as a whole, or in hospitals, or in private practice; or whether we take the absolute mortality for all the cities of Germany whose population is over fifteen thousand, and all the cities of France whose population is over twenty thousand; or the absolute mortality of New York City, or for the great hospitals in France, Germany and Austria; or whether we consider only the most fatal cases of diphtheria, the laryngeal and operative cases; or whether we study the question with relation to the day of the disease on which treatment is commenced, or the age of the patient treated; it matters not how the subject is regarded or how it is turned for purpose of comparison with previous results, the conclusion reached is always the same, namely, there has been an average reduction of mortality from the use of antitoxin in the treatment of diphtheria of not less than fifty per cent., and under the most favorable conditions a reduction to one-quarter, or even less, of the previous death-rate. This has occurred not in one city at one particular time, but in many cities, in different countries, at dif-

ferent seasons of the year, and always in conjunction with the introduction of antitoxin serum and proportionate to the extent of its use."

CYSTITIS AND URETHRITIS IN WOMEN. MEDICAL TREATMENT,
HOMŒOPATHIC AND PALLIATIVE.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, Washington, D. C., June 20, 1900.)

IN conformity with the new light which has been cast upon the etiology and pathology of cystitis and urethritis by the study of bacteriology and of pathological anatomy, in addition to the improved methods of direct examination of the diseased areas by means of the cystoscope, the treatment of these disorders has undergone some modifications. It is requisite for successful treatment that an accurate diagnosis be made, both as regards the cause of the disease and in respect to the pathologico-anatomical lesion. These considerations having received attention in the previous papers of the Bureau, it is my task to present the local and medicinal treatment, while the surgical requirements will be considered by another member.

It has been a very general experience that it is far easier to prevent urethritis, and especially cystitis, difficult as that may sometimes be, than to cure these inflammations after they have once been allowed to supervene in a given case. Their prevention, therefore, has an exceptional importance. Even at the risk of repetition it seems desirable to speak of prevention, and to direct attention to the proper use of the catheter. In women the two occasions which most frequently precede inflammations of the lower urinary tract, during which the use of the catheter is required, are after operations and during the puerperium. Dirty catheters and other instruments are mostly responsible for inaugurating inflammation where the cause, that is the infection, has been introduced from without the body. Indeed, it may be said that heretofore this cause has been more frequent than all others combined. It cannot, therefore, be too strenuously insisted upon, when the catheter or other instrument is to be introduced into the bladder, that the instru-

ment shall be first sterilized. The introduction of the glass catheter has done much to obviate the danger from this source, in view of the fact that the glass instrument is capable of sterilization by any and all of the means now employed for obtaining aseptic instruments. But let us ever insist that these means, some of which are certainly always at hand, shall invariably be made use of before the instrument is introduced into the meatus urinarius of a woman.

A consideration of equal importance with that just named is ever to keep in mind the fact that even with a sterilized instrument it is possible to carry infection into the bladder, if the parts adjacent to the meatus urinarius be not first cleansed from the secretion which at all times is there found, and which has recently been the subject of so much bacteriological research. Many varieties of germs capable of inducing septic infection have been demonstrated to flourish in and about the vulva. Now it is manifestly a flagrant fault in technique to take pains to obtain a sterile instrument, and then to be unmindful of the septic fluids through which the instrument may pass while on its way to perform the object of its use. It is consequently of the utmost importance that the vestibule and the meatus be cleansed of the secretions there found before the introduction of any instrument. But in order to effect this we must depart from the teachings of former times, wherein was eloquently described how the patient was to be covered up so that the genitalia should be protected from the desecrating peep of a single ray of light, while the index finger, beautifully trained, and possessing that *tactus eruditus* of which we sometimes hear, but disregarding altogether the swarms of septic micro-organisms there present, found the tubercle which marks the urinary meatus and triumphantly passed the germ-laden catheter into the bladder! Many of those in a position to know will bear me out that this prudery is responsible for much suffering during protracted periods in many instances. In brief, therefore, the parts must be exposed and treated in the way suggested if the future health of the patient is to be conserved. It is particularly necessary to follow this suggestion during the puerperium, when the lochial discharges bathe the parts already excessively sensitive to the action of septic germs by reason of the bruising to which they have been

subjected during the birth of the child. Let us also not forget that the use of the catheter is to be abandoned in a case as soon as the exigencies of the case will admit, in view of the fact that a certain amount of traumatism attends even the careful use of the catheter, and hence the oftener it is used the more likely is the patient to develop a cystitis.

In acute cases recumbent rest is advisable. The diet should be unstimulating, free from condiments, and should consist mainly of milk. Alcoholic beverages should be altogether interdicted. Mucilaginous drinks serve to dilute the urine and render it less irritating. If there be much pain and tenesmus the hot sitz-bath will afford relief, as well as the copious vaginal douche. The same may be said of hot applications to the hypogastric region—either hot turpentine stupes or the hot bran bag. If pain and tenesmus are excessive, an opium suppository or an anodyne injection into the rectum may be required.

Acute urethritis in women is not the formidable disease that it is in the male, and rapidly runs its course. Acute cystitis is more severe, but may be successfully treated by our homœopathic remedies. It has long been found that acute cases are not suitable for local treatment.

When the cases have assumed a subacute or chronic form, which is the stage in which they are more frequently seen, the general hygienic and dietetic treatment as outlined should be continued. It may further be said that a persistent effort should be made to dilute the urine by the copious drinking of water. Cases are recorded which have not been benefited until this simple but important measure has been carried out. It has likewise been found that keeping the bowels freely open materially benefits cases of cystitis. Skene and others report cases which have been unexpectedly but materially relieved by persistent catharsis.

It is now essential to be guided in large measure by the cause of the disease and the exact pathological lesion present, and local treatment, palliative or surgical in character, must be applied. The cases which are not handled in this manner become intractable and embitter the existence of the sufferer. A primary necessity is to endeavor to determine the cause and to remove it. In many instances this will alone comprise the treatment. If the cause consist of a stone or other foreign

body in the bladder, its removal, followed by a few repeated irrigations of the bladder, will be sufficient to cure the case. If diverticula exist in the bladder, as for instance in so-called cystocele, or in procidentia uteri, on account of which the bladder is unable to completely empty itself, the removal of this cause by means of plastic surgery is above all things demanded.

In view of the excessive irritability of the bladder, which in some instances has very closely simulated cystitis, but which has been found to have been induced by a retroverted uterus, a vaginal examination should in every instance be made, in order to discover and to remove the causes of any irritation in the pelvis which might be reflected upon the nervous condition of the bladder.

If the cause reside higher up in the urinary tract—as, for instance, in an infected kidney—the inflammation in the bladder and urethra are but secondary, and cannot be cured prior to the surgical treatment of this condition.

Several of the forms of chronic cystitis have their origin in inflammation which has not begun in the mucous lining of the bladder. Under these circumstances—as, for instance, in pericystitis, where the inflammation has really become a vesical peritonitis by extension of inflammation from the appendix, uterus, tubes, ovaries, or from pelvic exudates—the treatment will be included in that called for by these lesions. In this manner many women are relieved of the vesical irritation from which they have long suffered, when the proper treatment for the pelvic disease is instituted. The same may be said of paraecystitis when it occurs in women.

Interstitial cystitis, which involves the middle tunic of the bladder, and which may arise from either side, must be treated according to the local measures about to be indicated, if it can be reached from within the bladder.

Endocystitis, which is the form usually understood in speaking of chronic cystitis, imperatively demands local treatment, for therapeutic measures, no matter how carefully selected, will often be found to be disappointing when used alone, and the case will thus be permitted to protract an already lengthy course.

It has been shown by a number of investigators that the re-

action of the urine is dependent upon the character of the bacteria present, and the abnormal constituents and properties of the urine have their origin in the bladder itself. In consequence of the abnormal changes in the urine which are in the nature of decomposition, regardless of whether the urine be fetid or not, there is considerable irritation of the already inflamed areas in the bladder, and there is thus formed a vicious circle which must be disarranged. If the urine be excessively acid, and irritating on that account, the salts of lithium, the citrate or carbonate, administered several times per day in an effervescent draught, will correct this condition. The same is true of the citrate of potash, twenty grains three times per day. If there be excessive alkalinity, as is the case from a mixed bacterial infection, benzoic acid in ten-grain doses three or four times daily, or the benzoate of ammonia, which is more soluble, is spoken of as a specific by a number of old-school authorities.

Of boric acid, in 10-grain doses every three hours, it has been said that there is no case that can resist this treatment. Salol in 5-grain doses is given in ammoniacal decomposition. It will relieve the odor, tenesmus and pain, and the bacteria diminish in number. Salicylate of soda is advised for the same purpose. Copaiba, oil of sandalwood and oil of eucalyptus in 5 to 10 minim doses exhibited in capsules have given good results, especially in cases depending upon gonorrhœal infection. Corn silk, which has some reputation among the laity, administered in an infusion, is said by Kelly to be the best drug to allay irritability of the bladder when given in half-drachm doses of the fluid extract. *Triticum repens* in the same form is also recommended. Saw palmetto has recently been very generally used, and with good results.

In view of the fact that cystitis is a disease dependent upon bacterial infection which produces areas of inflammation not readily capable of cleansing themselves,—a condition also favored by the urinary changes of an irritating character,—one of the first requirements for successful treatment is to act in accordance with the fundamental principle of the modern treatment of inflammation, namely, to keep the parts clean. This may be effected by irrigation of the bladder. The reflux catheter attached to a fountain syringe is the apparatus often used.

Personally I use the more simple apparatus advised by Skene and others, and have found it amply sufficient. A further advantage, which on several occasions has been valuable, is that the apparatus may be improvised at a few moments' notice. It consists, as is doubtless well known, of a small glass funnel, which is connected with a glass catheter by about two or three feet of rubber tubing. The catheter, attached to the rubber tube and funnel, is introduced into the bladder, and the contained urine removed. By holding the funnel upright, but below the level of the patient, a quantity of urine may be collected in the glass funnel for inspection. Before the urine has entirely ceased to flow from the bladder the funnel is filled with the irrigating fluid, and then by elevating the funnel the fluid enters the bladder. No air should be allowed to pass into the bladder along with the fluid, and this may be prevented by being careful not to elevate the funnel before it is filled with the fluid to be injected.

The quantity of the injected fluid must be limited to from one to about four ounces, the rule being to cease the injection on the appearance of pain. When the glass funnel is lowered the injected fluid will siphon out of the bladder, and if the rubber tube be clamped, the glass funnel will again serve for inspecting the fluid returned from the bladder. This procedure must be repeated several times until the returned irrigating fluid comes away clear. This method of irrigating the bladder has the advantage also of permitting the force with which the irrigating fluid enters the bladder to be constantly under the control of the physician, and it can be immediately moderated as required. Too rapid introduction of the irrigating fluid is painful, unnecessary, and can readily be prevented.

The fluid to be used in washing out the bladder may consist of salt or boracic acid in about 4 per cent. solutions. The beneficial results obtained from them are considerable, especially in recent cases. Carbolic acid in 1 per cent. solution is useful when there is much pus present. Bichlorid of mercury is an efficient agent, in 1-100,000 to 1-10,000 solutions. The irritating properties of the drug, due to the injection fluid containing so small an amount of inorganic matter, may be overcome by adding the bichlorid to normal salt or boric acid solutions, instead of using plain water. Nitrate of silver has received very

general commendation. It is to be used in one-tenth to one-half per cent. solutions, which may later be increased in strength. Of the newer silver salts, the citrate in 1 to 4000 or 1 to 10,000 solutions, and protargol, are advocated. Potassium permanganate in 1 to 4000 solutions is also used. Goldspohn* sees more positive and quicker results from irrigation with one-quarter to one-half per cent. solution of oil of cloves than from saturated solutions of boric acid. He has seen rather uniform total removal of sepsis from the bladder without recourse to nitrate of silver. In one case, where I suggested its use, it was thought to have caused considerable vesical tenesmus. In the treatment of cystitis it is necessary that the irrigations be repeated at least once per day, or twice daily when the milder solutions are used.

Instillation is another means of treatment, and consists in introducing more concentrated solutions in much smaller quantities. In this manner are used silver nitrate 1 to 2 per cent., bichlorid of mercury 1 to 5000 to 1-500, and 5 to 10 per cent. emulsion of iodoform. Rovsing† recommends 40 c.cm. of a 2 per cent. nitrate-of-silver solution, and says that so certain is the action of this remedy that if it does not benefit, a complicating pyelitis may be assumed.

The introduction of the cystoscope has not only advanced our ability for accurate diagnosis of cystitis, but has made possible the efficient application of medicaments to the localized inflamed areas alone, without affecting the other portions of the bladder. When thus applied, the above-named solutions may be used in greater concentration.

Chronic urethritis in women may also be successfully treated by means of the cystoscope or the urethral speculum, applying the stronger solution of the silver salts. I have also rapidly relieved a case by urethral injection of antinosine 2 per cent. solution twice daily.

The following are the indications for some homœopathic remedies which have received ample verification :

Aconite: In acute cases; from exposure to dry cold; with high fever, restlessness, and anxiety of mind; frequent urging,

* *Amer. Gyn. and Obs. Jr.*, 1889, 69.

† *Centralblatt für Gynakologie*, 1899, 361.

with burning in the bladder; urine scalding, emitted in drops; is scanty, dark red, or bloody. Retention of urine in infants, with restlessness and crying.

Ammonium carb.: Violent tenesmus of bladder, with cutting, even at night; urine scanty, with burning; blood oozes from urethra.

Apis mel.: Great irritability of the bladder; frequent urging, with smarting in the urethra; urine dark, scanty, bloody; thirst absent. After abuse of cantharides and other irritating drugs.

Arnica: Traumatic inflammation; urine scanty, with thick brown sediment.

Arsenicum alb.: Burning pains on beginning to urinate; bladder distended without desire to urinate; retention of urine after parturition; great thirst; restlessness; urine turbid, bloody or purulent; in typhoid states, sepsis and collapse.

Asparagus: Tenesmus; urine with pus and flakes of mucous lining of bladder; constant urging; burning during and after micturition.

Belladonna: After aconite, plethora; region of bladder sore and sensitive to touch; urine scanty, red, hot, later with copious slimy, red deposit; involuntary dribbling; pains come and go suddenly; backache as though it would break.

Benzoic acid: Irritable bladder, with pain when not urinating; dribbling of urine; incontinence, especially at night; urine hot, dark-red, scanty, acid reaction; with strong odor; ammoniacal; very offensive; muco-purulent and phosphatic sediment.

Berberis vulg.: Back sore and lame, with urinary symptoms; burning, pressing and cutting pain in the bladder; vesical tenesmus; sediment copious, slimy; urine red, turbid, yellow or bloody. Pain from kidney to bladder; ought to be a valuable remedy in ureteritis.

Camphora: Strangury, discharge in drops; tenesmus of the bladder; retention or slow emission; burning in the bladder and urethra; urine red, thick. Inflammation caused by cantharides, turpentine, etc. Coldness of the extremities. Is successfully used by the old school in combination with opium as a urinary sedative in acute cases.

Cannabis Indica: Burning, scalding, stinging in urethra

before, during and after urination; contains much mucus; dribbles after stream ceases; must wait before urine flows. After exposure to cold.

Cannabis sat.: Pain in neck of bladder and both kidneys; urging every few minutes; tenesmus worse after urinating.

Cantharis: Intense burning and cutting pains in the bladder; violent tenesmus; stinging, burning, cutting pains in the urethra; violent ineffectual urging; discharge in drops which feel like hot lead passing through urethra; constant desire to urinate; urine scanty, turbid, bloody, albuminous, containing shreds of mucus.

Causticum: Cystitis with incontinence; must greatly hasten to urinate when the desire is felt; involuntary discharge on coughing; retention with difficult expulsion; pale urine with flocculent sediment.

Chimaphilla: Chronic cases; violent tenesmus; urine scanty, high colored, turbid, bloody; abundant stringy sediment passed, with pain before, during, and after; great difficulty in commencing to urinate. Constipation.

Colchicum: Vesical irritability depending upon a gouty diathesis.

Colocynth.: Alternate stitches in bladder and rectum; urine fetid; soon thickens, becomes viscid or turbid, with copious deposit like gravel.

Copaiba: Burning in neck of bladder and urethra; urine passed in drops; frothy, dark yellow, with odor of violets.

Cubeba: Chronic cystitis; cutting after micturition; last drops painful; urine foamy, bloody, smelling like violets.

Dulcamara: Chronic cases; constant urging; urine contains much mucus; foul, scanty, turbid; paralysis of the bladder. After exposure to damp cold.

Elaterium: Inflammation of the neck of the bladder; violent pains when urinating, inducing even convulsions.

Equisetum: Constant fullness and dull pain in the bladder; frequent urging; bladder tender; urine scanty; sediment abundant; mucus; enuresis; a valuable remedy; acts similarly to cantharis, but has more mucus sediment.

Eucalyptus: Incontinence; dysuria; catarrhal cystitis.

Gelsemium: Frequent urging with scanty emission and tenesmus; spasmodic retention.

Helonias: Nervous atonic states of women; involuntary urination after bladder seemed empty; pain and lame feeling in back; great debility, better when she is at work.

Hyoseyamus: Retention of urine, bladder greatly distended; urine turbid; mucus, purulent sediment; great thirst; dry tongue; subsultus tendinum; delirium; hysterical subjects.

Kali bichrom.: Continuous desire to urinate in daytime; sensation as if one drop had remained behind; urine strong-smelling, alkaline,ropy.

Kali carb.: Violent cutting and tearing in bladder and urethra; deposit red mucus, purulent.

Lachesis: Vesical catarrh; urine offensive, mucus; sensation as if a ball were rolling in bladder or abdomen when turning over; urine almost black, foaming, burning.

Lilium tigr.: Frequent tenesmus, worse toward morning; urine hot like boiling oil.

Lithium carb.: Sharp pressure in vesical region; itching stitches through pubes; worse evening when walking; urine scanty, dark, acrid; sediment dark red or brown.

Lycopodium: Chronic cases; calculi; urine frothy, milky, turbid; offensive purulent sediment; terrific pain in the back previous to every urination, with relief as soon as the urine begins to flow; hæmaturia; hæmorrhoids; constipation; flatulence.

Mercurius: Sudden irresistible desire to urinate; sweat during urination; region of the bladder sore; urine turbid, dark red, contains shreds of mucus. *Merc. cor.* especially has great tenesmus and bloody urine.

Nux vomica: Painful ineffectual urging to urinate; discharge in drops with burning and tearing pains; spasmodic retention of urine; urine pale, or thick with purulent sediment; constipation, hæmorrhoids; after abuse of drugs.

Pareira brava: constant urging, with tenesmus; violent pain; urine turbid; much mucus; ammoniacal.

Phosphoric acid: Constant urging; urine milky, with bloody, jelly-like pieces of mucus; decomposes rapidly.

Piper methysticum: Chronic cases with fetid urine; stringy gelatinous sediment, very adherent.

Polygonum: Painful cutting and constriction in bladder, continuing long after urinating; pain in sacrum and bladder, not relieved by voiding large quantities of pale urine.

Populus: Urine scanty; much mucus sediment; violent tenesmus; cystitis in elderly persons.

Prunus spin.: Terrific burning in urethra; bladder is more comfortable when containing urine; scanty urine.

Pulsatilla: Frequent ineffectual urging with cutting pain; tenesmus; slimy sediment; after exposure to cold.

Sarsaparilla: Chronic cases; severe tenesmus; emissions of white, acid, turbid matter and mucus; during micturition air passes from the bladder; white sand in urine; offensive smell of genitals.

Senega: Vesical catarrh of old people; dark urine, frothy, with mucus shreds, on cooling thick and cloudy; great debility, weak legs, trembling and faintness on walking.

Sepia: Chronic cases; full feeling in bladder, with downward pressure; wants to hold up the abdomen; periodical discharge of mucus, sometimes in plugs; urine thick, slimy, offensive.

Sulphur: Jahr recommends it in obstinate cases, or when none of the preceding remedies prove efficient; urine mixed with mucus and blood, with burning in the urethra when urinating. Calcareo is often suitable after sulph. when the complaint is caused by suppression of hæmorrhoids; when calc. does not subdue the burning pains, arsenic or carbo veg. may be administered.

Terebinthina: Strangury; tenesmus; sensitiveness over the region of the bladder; burning in the region of the kidneys; sediment slimy, bloody; urine retained from atony in old persons of sedentary habits.

Uva ursi: Desire frequent, with burning, cutting pains; urine yellow, with profuse, tough, mucus sediment; burning and tearing in region of bladder; constipation.

Vesicaria communis: Has been empirically used with success in drop doses of the tincture.

AN UNUSUAL OVARIOTOMY. (Tipper and Philipps.)—The operators found a multilocular ovarian cyst with many adhesions. The cyst was incised, emptied, sewed together, and the abdominal wound closed, as the condition of the patient did not allow further operating. The pulse and temperature remained normal, and a week later the cyst was removed and the patient recovered.—*Lancet*, Oct. 7, 1899.

THERAPEUTIC HINTS IN THE MEDICAL TREATMENT OF UTERINE FIBROMA.

BY WALLACE M'GEORGE, M.D., CAMDEN, N. J.

(One of a series of papers on Uterine Fibroma read before the New Jersey State Homœopathic Medical Society, at its semi-annual meeting in Galen Hall, Atlantic City, Sept. 5, 1900.)

To treat successfully patients afflicted with uterine fibroma requires care in observing subjective as well as objective symptoms, skill in differentiating the remedy, and faith in the curative power of the drug decided to be homœopathic to the case.

The pathology and diagnosis of uterine fibroma have been so clearly stated by Dr. L. E. Griscom in his paper, the surgical treatment so aptly given by Dr. George D. Woodward, and the electrical treatment so plainly set forth by Dr. A. W. Baily, that my work will be much easier in the "Therapeutic Hints" for the medical treatment of this class of cases.

"The medical treatment of these growths is chiefly palliative, and consists in the prevention of hæmorrhage, the relief of pain, and the maintenance of the general health. In some rare cases, however, much may be done toward effecting a cure; and, indeed, cases are known in which fibroid tumors have completely disappeared during the administration of drugs." So wrote Dr. John Williams, in an article on uterine fibroids, in Reynolds' *System of Medicine*, in 1880. If the Old School, with their inferior system of therapeutics, could point to an occasional cure, how much greater reason have we for faith in the curative virtues of our drugs?

We will not dwell on the old-school plan of treatment, which can be read in any of their standard works, but we will pause long enough to warn against the prolonged use of ergot, hypodermically or otherwise, so highly extolled by some of their writers. Many patients find a speedy path to the grave through the indiscriminate use of ergot; many charming women have been quickly taken away from family and friends through the poisonous effects of this drug.

In studying the history of these cases, the question of metastasis should not be overlooked. Can the cause of the fibroma

be traced to the suppression of a skin disease, the drying up of a running sore, or the removal of an unsightly wen from the scalp or neck? Let us, if possible, find the cause, and then it will be easier to remove the product.

One case of interstitial fibroid of the uterus of twenty-five years' standing, that I have observed for many years, had uterine polypi thirty-three years ago, which were removed by the knife, and for many years a large wen on the scalp which was removed by surgical means in the year 1864. No other member of the family nor any blood-relative ever had fibroma. Fortunately for her, she has had homœopathic treatment for nearly twenty-five years, and now at 70 years of age, although carrying this mountain of flesh so many weary years, she lives to prove the truth of the statement that homœopathic medicines will retard the growth, will diminish the size, even if they have not removed, this unwelcome visitor. Had she been properly treated by homœopathic medicines for those uterine polypi away back in 1868 she might have entirely escaped this subsequent growth.

When a patient suffering with uterine fibroma is to be treated medically, it will save annoyance to the patient, and possible obloquy to the physician, if at the very commencement the patient or her friends are distinctly informed that the case will be tedious; that treatment may have to be prolonged for months, possibly years; that we cannot positively promise a cure; that we may only be able to palliate, and that when we find that our treatment is not doing all that is desired, we will truthfully state to the patient or her friends the exact condition of the case. Then we should go forward and look upward for help and Divine guidance; for, all other things being equal, that physician who trusts in God and realizes his obligations to his Maker, as well as his duty to his neighbor, will be more successful in the treatment of these cases than he or she who relies only on self.

The surgeon has his distinct line of duty, and there are cases where he lays down his knife and says he dare not operate. The surgeon is justified in declining to operate when the case is inoperable; the physician is never justified in refusing to prescribe for or treat these inoperable cases.

We have three classes to prescribe for. *Firstly*, Those cases

where the diagnosis has just been made and the trouble has not gone far enough to consult a surgeon. *Secondly*, Those cases where the patient is unwilling to submit to the surgeon's knife. *Thirdly*, Those cases that have been made ready on the operating table, and then after further examination been pronounced inoperable. In all these cases we should examine them carefully, thoroughly, prayerfully; then zealously labor to restore our patient to health and comfort.

Besides giving the remedy, we should see that our patients are surrounded with those influences that will remove unnecessary trials; that they have bodily rest and mental freedom; we should know that they are judiciously fed as well as tenderly nursed, and in our intercourse with them we should be hopeful and trustful, because if they see we are hopeful and faithful they will become hopeful and more at ease. After once telling the difficulties and possible dangers, I never say anything to discourage them. If they are growing larger, they know it without my telling them. If there is visible improvement, be sure and inform them; it will make them feel better and have more confidence in your skill. Keep the digestive organs in good condition, and avoid anything that interferes with the portal circulation.

Having selected the remedy, stick to it. Don't give any remedy until you decide what will do your patient the most good. Don't give it too low nor repeat too often. Don't expect immediate results in the fibroid, although you may expect immediate improvement in some of the concomitant symptoms.

And now for some hints in selecting the remedy.

Lycopodium was the remedy that benefited the first decided case of interstitial fibroid I have any notes of. By this I mean the first case under strictly medical treatment. This was in 1884, when I was attending the practice of a physician who had gone South for his health. The patient said the growth was three years old, that it had stopped enlarging, and she was more comfortable. While so much had been accomplished, she was willing to keep on with the treatment. She said it was this medicine or the knife, and although her physician was known as a skillful surgeon, she felt he could cure her without an operation. *Lycopodium* had been prescribed because it

covered her other symptoms, and not particularly for the fibroid. I understand this lady is still living, has lost none of her internal organs, but has lost the fibroid growth by absorption. She received the high potencies all through the treatment. *Lycop.* is useful in uterine polypi and in uterine cancer. Hering recommends it in erectile tumors and polypi; also in dry, pediculated, painless condylomata. He says *Lyc.* is suitable for old women, persons of keen intellect but feeble muscular development. Dr. Kent says: "*Lyc.* is suited to low forms of disease, chronic disease, corrosive forms of disease, such as we find in corroding ulcers of the stomach, eruptions like epithelioma, infiltrations beneath ulcers, manifestations of warty growths, of all kinds of fevers and eruptions of low anæmic conditions." *Lyc.* has pinching pains in internal organs, which leads us to think of it in uterine fibroids; all discharges are offensive under *Lyc.* except flatus, which is generally odorless. The following urinary symptoms may lead us to think of it: heavy sensation in bladder, burning on urination; urging to urinate, but must wait long before it will pass, or inability to void urine with constant bearing down; rumbling begins in upper abdomen and descends to lower part, when a flow of blood follows, and so on successively; uterine hæmorrhage.

Viburnum is a grand remedy in all uterine affections. It is the main ingredient in the preparation that made a fortune for Lydia Pinkham. There are two kinds. The kind mainly used in uterine fibroids is *v. opulus*. Some physicians use the mother tincture, others use the fluid extract. Very few use it in the high potencies. This remedy has controlled the metrorrhagia, relieved the pain, and prolonged the life of a lady who has suffered with a fibroid twenty-five years. She thanks the man who gave her viburnum, and attributes to this medicine, with its wonderful control of her terrible floodings, the fact that she has lived to see her children grow up to manhood. *Viburnum opulus* has a tonic effect upon the relaxed organ, and is better in its effects than a mechanical supporter. In neuralgia of the womb *v. prunifolium* in the 30th potency will give much speedier results. Beyond controlling the metrorrhagia and relieving the pressing down, I am not aware that viburnum has much effect in arresting the growth or causing its disappearance.

Terebinthina is good in those cases where the fibroid has come after using an uterine supporter; it is good in fibroid enlargement of uterus, with bloody, offensive leucorrhœa and terrible burning in the uterus; menorrhagia of black blood; where there is pain at the crest of ilium, worse from motion or the least jar in walking or riding; good also in passive hæmorrhages. Hering says that *chian* turpentine (which is made in the island of Scio, in the Grecian archipelago) is said to destroy cancer-cells, leaving the vessels to become atrophied. It acts on the periphery of the growth with great vigor, causing its speedy disappearance and entire cessation of pain in a few days. Would it not be well to try it in uterine fibroma?

Secale, in the high potencies, is useful, although Dr. Kidd, in the *British Journal of Homœopathy*, says that though it may be homœopathic to the symptoms produced by these tumors, yet that its use is only palliative, and in no way curative to the disease. He must refer here to *secale* when used in the crude state. In my opinion, in those cases where the patient cannot bear any clothing or bedcovering, and even in cold weather throws off the bedclothing—when she rejects all food and can keep nothing on her stomach—*secale cornutum* will be the remedy; but it should never be given lower than the 3d potency, and the 30th potency would be much more expeditious in its action. In these cases *secale* will settle the stomach, make them more tolerant of clothing, and work curatively on the enlarged and diseased uterus. Guernsey said to think of *secale* in thin, scrawny people; but I have seen just as good results from it in stout, fleshy people. A symptom that will lead us to think of *secale* is the subjective symptom that the uterus feels hard (similar to platina in this respect); it is good in cancer of uterus, in gangrene of uterus and in putrescence of uterus; it has dreadful bearing-down, dragging-out feeling in lower abdomen, so that her life is almost unbearable. Hering mentions a case of metrorrhagia where the patient did not wish to be covered, desired windows to be open, though the room was very cold and the surface of body like a corpse. I remember an occasion along in the '80s when I went to see the first President of the West Jersey Society, who was reported to be dying from gastritis. In addition to the constant retching and nausea was the desire to throw off all the bedclothing.

He looked very distressed, yet I hesitated to suggest anything for him, as he was under the care of the Dean of the Hahnemann College. But when urged by his wife to do something to relieve his distress and her fears, I advised *secale*, and his wife gave him some at once. When I saw him next day, he grasped me warmly by the hand, and said he wished I had come to see him before. His improvement was rapid, he was enabled to go down in his office in less than a week, and lived several years afterward. In irritability of the stomach accompanying uterine fibroma let us not forget *secale*.

Sabina is much used to control the metrorrhagia so frequently present in uterine fibroma; it has remittent but fixed pain in uterus, at times stitching in character, resembling *kali carbonicum* in this respect. The uterus is enlarged or swollen; when you have the characteristic pain in the uterine region, running from the pubes to the sacrum, with or without discharge of dark, clotted blood, *sabina* will serve you well.

Conium maculatum is an old remedy, but a good one in this class of cases. *Conium* will cure non-malignant tumors in mammae or uterus, even if of stony hardness, but in my experience will not cure cancerous growths in either organ. When the uterus is indurated, with burning, stinging pains, sometimes darting pains in cervix, or when hypertrophied with polypi, we should remember *conium*. It is also good in those cases where the polypus from uterus protrudes during stool, or where the uterus is swollen with lancinating pains in the os, with frequent copious metrorrhagia. The urinary symptoms will frequently help us in selecting this remedy. The pressure of the swollen uterus on the bladder interferes with the free passage of urine, and, after partly voiding, the flow stops and then starts again.

Sabal serrulata (or saw palmetto, as it is better known) has worked nicely for me in a case that has been pronounced inoperable by the surgeons of Hahnemann Hospital in Philadelphia. This patient had been operated on in 1896 in another hospital, and was told that she would be entirely well when they were through with her; what was done she does not know. Four years later she was sent to the Hahnemann for hysterectomy, but after being prepared for operation, a more careful examination, while she was under ether, resulted in the opera-

tion being deferred, and as soon as she was well enough her friends were asked to take her away. She came under my care early in March of this year. She was quite swollen, confined to her bed, and every movement resulted in a flow of black, slimy blood. She was more comfortable when she lay on her back, and was afraid to move. Bryonia did her some good; later, on account of her bad color and the sluggish portal circulation, she received mercurius with much benefit, but it did not help her uterine trouble. Sulphur was tried; then she had viburnum prun. 30 for the sharp, neuralgic pain in womb. The pain was relieved, but the discharge from vagina was not controlled nor affected in any way. She was very weak, and complained more of that than anything else. Hale, in his book on saw palmetto, says it is an excellent tonic, and particularly improves the sexual organs, and I thought of this remedy for her. It had done capital service for me in cases of enlarged prostate; why might it not reduce an enlarged womb? To decide was to act, and I gave her *sabal ser-rulata* in the first potency. In five days there was improvement; in ten days she wanted to sit up; in fifteen days she was out of bed and down stairs. Her general health had improved, and the bloody discharge had ceased, only returning after she took too much exercise. In one month's time the improvement was still more marked, and in six weeks I stopped making visits, because she could send to the office once a week and renew her medicine. Of course, this is only palliative, for the tumor remains there. Still, if she improves, she can put up with that inconvenience. I have made no vaginal examination since May, and cannot tell what changes have taken place there. I am content to let well enough alone, and as long as she improves I shall not change the medicine. So far as I could tell from a digital examination, it is a case of hardening of the lower portion of the body of the uterus, with a spongy, easily bleeding surface at the orifice. I cannot say so, for that and a part of the cervix may have been removed. The discharge was dark, almost black, bloody, not clotted, rather slimy, not offensive in odor. *Sabal* covers very many of the urinary symptoms present in fibroma, and is very good to remove the mental depression so frequently found in these cases. It is a remedy that can be given repeatedly without bad results.

Mercury is one of the greatest alteratives the old school has, and many people, from its continued use or abuse, have been altered for the worse. In our treatment *merc. sol.* has been found very useful in deep ulcers on cervix and os with ragged edges, which bleed easily when touched. From analogy it ought to be useful in uterine fibroma, for we know there is no better remedy in indurated cervical or abdominal glands. When the portal circulation is sluggish, or when the liver is torpid or inactive, fibroid tumors will thrive, and an improvement in the hepatic region will surely be followed by relief in the uterine region. Jahr recommends mercurius in metrorrhagia, and mentions the case of a female who had not menstruated for eleven years who had metrorrhagia which lasted three weeks, but was finally cured by mercury. If the fibroid is of specific origin, or if there is a fear that such is the case, mercurius would be a good remedy to begin treating the case with. Fibroid tumors of the uterus with profuse muco-purulent excoriating leucorrhœa, leads us to think of mercurius corrosive sublimate, while in fibroids of stony hardness the red iodide of mercury is said to be more useful.

Ustilago maidis has been used in subserous and interstitial fibroids, and they have diminished in size, and the patients have improved from its use. The uterus is sensitive as well as hypertrophied, and bleeds when touched. Hering mentions a case of hypertrophied uterus, with a soft and spongy os and cervix, sufficiently dilated to easily admit fingers. The blood is dark, and so thin as scarcely to color fingers; fibroids and indurations of os; constant aching, referred to mouth of uterus; cervix tumefied; tissues of uterus feel spongy in subinvolution; in metrorrhagia the blood is light, fresh, and does not coagulate; it is good in menorrhagia at climacteric periods. It has been used with good effect in hypertrophy and subinvolution of uterus with great atony.

Tarantula has heaviness in uterus, with burning, as if there was not sufficient space, with upward pressure; fibroid tumor of uterus with bearing-down pains. In a case of fibroid accompanied with neuralgia, the patient improved under *conium*, and was cured by *tarantula*.

Platina is good where there is excessive sensitiveness of all the genitals; where the uterus feels hard subjectively (see also

secale); in fibroids where the hæmorrhage comes in clots; where there is continued pressure in groins and back; think of it in brunettes or in Italians.

Arsenicum.—Good in scirrhus when the os is hot and worse from motion; burning predominates; good in non-malignant tumors; hard, nodulous swellings.

Calcarea carb.—Bearing down in fibroid of uterus; uterus low down; os open to admit finger; smooth body (fibroid) felt within; profuse metrorrhagia of light blood in fibroids.

Iodine has induration in os, with long-lasting metrorrhagia; pain in loins in cancer of uterus; hæmorrhage in uterus, renewed after every stool.

Colocynthis is said to have improved a fibroid, firm and elastic, between uterus and vagina anteriorly and rectum posteriorly, completely occluding vagina, and rendering defecation difficult. It is said to be good in painful cases of cancer of the uterus.

Ledum palustre has been recommended in fibroid tumors or polypi with menorrhagia, in which there was a constant draining away of blood; in those cases where the patients have an obstinate swelling of the feet it is more likely to be the remedy.

Kreosote is good when the induration is more on cervix than anywhere else, with ulcerative pain; good when there is constant vomiting with inability to retain food on the stomach; in scirrhus of vagina painful to slightest touch; orifice of uterus wide open, almost everted, its inner surface like cauliflower; fundus of uterus swollen and sensitive to pressure; metrorrhagia dark and offensive, with fainting; the patient is pulseless for a time.

Xanthoxylum is highly extolled in uterine troubles, but apart from its usefulness in excessive hæmorrhage, I know of no indications for its use in fibroma. For violent after-pains, accompanied with extreme sensitiveness to pain, *xanth.* may go up head. It has a great influence in restoring the uterus, after parturition, to its normal condition, and it may be well, for those who have opportunity, to test it in uterine fibroma.

Esculus hippo. has indurated cervix, accompanied with tenderness, heat, throbbing; for those cases where pain is felt more posteriorly or in the rectum, it may be thought of. It also has aching in sacrum, extending down to the knee.

Rhus tox. was used in a case where the posterior wall of the uterus was softened, almost filling the entire cavity of the pelvis.

Kali carbonicum has fibroid tumor with tendency to metrorrhagia; tumors with dysuria and rising at night to urinate; fibroids with flatulency, or with stitching pains.

Kali iodide has predisposition to metrorrhagia from fibroid tumor; subinvolution, enlargement and hypertrophy.

Of the Tissue Remedies, *calcareæ fluor.* and *kali mur.* are the only ones mentioned by the biochemists as being necessary in fibroid growths. *Calcareæ fluor.* is used "to tone up the contractile power of the uterus." It is good for dragging pains in uterine region and thighs, also in small of back. It is used in hypertrophy of uterus with stony hardness. If the patient has lumps or "knots and kernels in the breast," or varicose veins of the extremities, the indications for *calc. fluor.* will be much stronger.

Kali mur. is recommended in "enlargement of the uterus when not of stony hardness," and is frequently alternated with *calcareæ fluor.* It is good in "chronic congestion of the uterus," when exudation has taken place, causing "hypertrophy of the uterus."

For the intense neuralgic pains sometimes present in fibroids, due to pressure of the tumor on the adjacent nerves, *magnesia phos.* is very helpful. I have derived benefit from using it in the 6th decimal trituration. Dr. Carey recommends a small quantity of the remedy dissolved in hot water and applied with cloths (as hot as can be borne) immediately over the uterus in membranous dysmenorrhœa. It might be well to use it the same way in fibroids. Whether applied externally or not, the medicine, when taken internally, should be taken in hot water, and not in cold water. I had one patient who begged me never to leave her without some of these powders, so she could use them in the paroxysms of pain.

Many other remedies might be mentioned, but this paper is already too lengthy.

Let the remedy selected cover the totality of the symptoms, and then give it unhesitatingly, without regard to the fact that you never heard that it had been used in such pathological conditions before. The true physician treats his patient, and you will be more successful if you pay greater attention to drug pathogenesis than to pathology.

THE RECOGNITION, PREVENTION AND CONTROL OF RHEUMATISM AND ITS CARDIAC LESIONS IN CHILDHOOD.

BY WILLIAM W. VAN BAUN, M.D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, Washington, D. C., June 20, 1900.)

THE tendency to cardiac affection in rheumatism of child life awakens an interest in the prevention and control of the rheumatic infection and its impending carditis. In children fatalities may be traced directly to the rheumatic attack, while such a result in adult life is so rare as to call forth special comment.

The clinical study of disease in children soon destroys the confidence of earlier ideas, which, while antiquated and outgrown professionally, are still more or less deeply rooted and firmly held by those who are responsible for the health and well being of children; for the notion still prevails that heart disease is rarely found in childhood, and when found, the child, having the advantage of youth, will outgrow the disease, especially with the approach of adolescence.

The truth is, heart disease is unfortunately altogether too prevalent, and it is too frequently overlooked or ignored when a child is brought for remedial attention for some of the numerous less serious but more annoying conditions of child life.

A free outlining of the rheumatic picture in childhood shows a great diversity of early symptoms; trivial arthritis; unsatisfactory evidence of rheumatic origin, and pronounced nervous phenomena. Sudden cardiac failure, often fatal, with inadequate anatomical changes to account for such an ending. Later, a rapid or gradual oncome of peri-endocardial murmurs. Even in an original attack of rheumatism the endocardial murmur may be delayed or of slow origin, it may follow an attack of short duration and of no severity, and really be a sequela. The rheumatic infection in children may not prove rapidly fatal, but it often causes such serious cardiac damage that the victim dies during adolescence or in early adult life. This startling phase of the clinical history creeps on silently and

unobtrusively, the toxic poison invading the heart structure, and producing incurable results; so it will not do to wait for the development of definite cardiac murmurs before giving active battle to arrest and turn aside the rheumatic advance. It is true that partial victory may be all that is within reach, even before the advent of endocardial indications. This simply emphasizes the necessity for the early recognition of a possible onset of rheumatism, and its complete control before cardiac involvement takes place, and this requires an alertness of diagnosis and preventive treatment which has not hitherto been sufficiently exercised.

It is manifest that prevention is the keynote of success in the treatment of these cases; and that prevention is impossible without early recognition. Therefore recognition becomes important. It is unnecessary to dwell upon the classical symptoms of rheumatic infection. When present they will be recognized; but it is necessary to realize that one of the chief characteristics of rheumatic invasion in childhood is that the younger the subject the less likelihood of finding joint-affection and the greater liability to endocarditis and valvitis; and, other things equal, the greater the peril to life.

The failure of early recognition of both rheumatism and its associate heart affection comes from overlooking the importance and significance of the symptomatic expression of the infection. The clinical picture is at variance with that found in adults; the articular feature is usually in abeyance or may be altogether wanting. In childhood the mildest attack of rheumatic fever may insidiously usher in an affection of the heart of serious import, and the clinician should always be alert and responsive to the slightest indication or signal of danger; yet a warning frequently found in undeveloped cases is often swept aside as unworthy of consideration, with the old, trite remark of "growing pains," with never a thought as to their possible rheumatic origin.

In this connection, when inquiry is being made to ascertain the cause of an established disease of the heart, especially of mitral stenosis, in childhood, the quest for the rheumatic origin must not end with the negation of rheumatism, chorea, tonsillitis or joint pains. A call for "growing pains" will often bring an affirmative. The percentage of children who suffer

from pains in the ankle, knees or wrist—with leg pains or leg weariness—the so-called “growing” pains—is large, and the pains or distress is as a rule of rheumatic origin, and no matter how insignificant they may be to the parents or guardians, they are of sufficient importance to claim active medical attention and frequent systematic chest examinations. Early recognition of cardiac complications with the prompt institution of preventive and remedial measures will save the valves from permanent crippling, and may ward off entirely the infective inflammation with the unfortunate cardiac lesions, so often painfully in evidence during adolescence.

The unhappy cardiac results of rheumatic infection at this period of life are not, as a rule, due to endocarditis. It is admitted that it is almost always found to a greater or lesser degree in each fatal specimen—but it is frequently so slight in extent as not to have been a factor in the cause of death. On the other hand pericarditis is by far the most important element contributing to the fatal termination; not the simple adhesion of the opposite surfaces of the membrane, but where there is widespread adhesion between the two layers and the external tissues of pleura and mediastinum. When such a result can be demonstrated to exist in the living by means of the physical signs the prognosis is decidedly grave.

Effusion in these cases of pericarditis has not the importance that is usually attributed to it. It is seldom a factor in fatal pericarditis, for clinical testimony in opposition to the textbook teaching shows that fluid is present in only a small percentage of cases, and then only in small quantity, about two ounces, rarely, if ever, reaching six ounces. In such cases the rheumatism is to be considered as a toxæmia of which both endo- and pericarditis are pathological manifestations, and that the real source of danger is in the muscle walls of the heart, which, by the way, can be involved to a fatal termination without a coincident inflammation of the inner or outer membrane of the heart. When considering the heart walls as the special seat of the pernicious influence of rheumatic poisoning, it is to be remembered that the visceral pericardium is really a part of these walls, and that they hold responsive relations with each other; that the connective tissue of the former dips down into the substance of the muscular walls, and when inflamed does

infinite damage to this important structure. A serious inflammation affecting the visceral pericardium cannot exist without at least involving the superficial area of the heart walls. How great this damage may be cannot be determined ante-mortem with the means at our command. Such a situation is unfortunate and calls for critical research to establish definite data. That pericarditis does weaken the heart muscle is beyond question, and this weakening is a point of grave departure, for the damaged muscular structure will yield to the internal blood pressure, and dilatation with its alarming outlook supervenes.

A dilatation need not be fatal to be serious. The fact is present that a child who has once suffered from rheumatism is always liable to recurrent attacks and the dilatation of the first attack may not have subsided before the oncome of the second, in which case, it becomes more emphatic with each subsequent seizure; the heart becoming enlarged to a size awakening incredulity, if one has not seen it removed from the chest.

There may be considerable dilatation of the heart occurring irrespectively of valvular or pericardial inflammation, due to the direct action upon the cardiac muscle. In such a case the first sound of the heart will be shortened and the second pulmonary sound will be accentuated, with feeble pulse, pallor, listlessness and lack of muscular tone.

Lees, who has given much time and thought to this question of dilatation, insists that more or less dilatation is usually present in a rheumatic attack, even where there is no proof of either peri- or endocarditis; for there may be subacute attacks, with slight pyrexia and little arthritis, either in adults or in children.

In acute rheumatism in children, when there is a rapid increase in the area of præcordial dullness, it is extremely important not to attribute this to an effusion into the pericardium, for it is so often mainly or altogether due to acute dilatation.

Granted that hypertrophy may be present in some of these cases, it is not necessarily of the compensatory type, and we must avoid being misled, for it may not be genuine, but as has been suggested, it is merely a thickening of the heart-wall by œdema and inflammatory changes, and is really an added cardiac weakness.

From this it is to be gathered that two conditions contribute

directly to the serious cardiac crippling, or to the fatal results—that is, plastic pericarditis and dilatation.

In weighing a prognosis it is not sufficient to demonstrate to one's own satisfaction the presence of an endocardial or valvular murmur; this may be of small importance in comparison with the essential facts, the presence of pericardial friction and the evidence of cardiac dilatation.

In regard to the outcome of an inflammation affecting either the endocardium or pericardium, or of a general acute carditis, a daily change or variation in the character of the murmurs, or in the rhythm of the heart's action, has a peculiar significance and indicates the presence of an active attack, no matter how long standing the disease may be. And no matter how rigid the treatment may be or how complete rest may be maintained, the child is in real danger as long as these conditions prevail.

Again, when a child is subject to repeated attacks, sometimes so near together as to appear like one long-continued illness, there is special danger, for each succeeding attack, however trifling in itself, causes new damage to the heart's structure, and it cannot long maintain a successful resistance to the repeated onslaughts.

In prognosis it is difficult to be precise and impossible to be positive, but on the whole the outlook is good, for with rest alone, carefully and systematically carried out, there are often marked recoveries from failing compensation; and murmurs will sometimes disappear, either partly or altogether, with the oncome of adolescence. Dilatation is not always an unmixed evil, sometimes it may act to the advantage of the individual, especially where plastic pericarditis exists with its subsequent adhesions. It is better for the future free action of the heart that the dilatation should continue as long as the inflammation shall last, for in the future the heart's action will be much less constricted than if bound tightly down. The prognosis is not good where the dilatation is due to the rheumatic poison affecting the heart-muscle itself, and especially if there is a persistent recurrence of general rheumatic manifestations, like tonsillitis, arthritis, growing pains, rheumatic nodules, chorea, etc.

We understand the varying virulence and recognize the individual effect of rheumatic infection, but there is no accepta-

ble explanation why the action is such. We know that juvenile cases of rheumatism exist without arthritis, and without evidence of valvular or pericardial disease, and, at the same time, suffer an unaccountable breathlessness, præcordial distress or pain, and present other symptoms of cardiac strain. This, we say, is due to rheumatism injuring directly the heart-walls and impairing its force and action to the degree that death may be imminent. Yet, in another case, with the same exposure, there may simply be a mild arthritis, with no subsequent damage.

It is easy enough to state that the cardiac complication is due to rheumatism. But what is rheumatism? With our present knowledge the cause giving rise to rheumatic infection is not satisfactorily understood. It is reasonable to class acute rheumatism as an infectious disease, but as yet no one special organism has been demonstrated as its causative factor; all we know is that there seems to be an association of bacteria. Toxin absorption accounts for many cases, and research along clinical lines gives evidence that the tonsils furnish a pregnant vestibule for the infection. Avoiding the beaten highway of established facts and the by-ways of "infective theories," we come to the cross-roads of the "infective factor" and the "individual predisposition," and the question arises, What is it that exposes one child to more or less destructive rheumatic poisoning, while another in apparently similar circumstances undergoes the same exposure, fatigue or depression without harmful results? Until bacteriology supplies us with more positive data than we now possess, the answer will be held in abeyance, and prophylaxis will be limited to sanitation, individual and environment, the latter being carried out on principle without discouragement or laxity, and with full knowledge that even with all possible care rheumatism will assert itself.

When we reach for the control of the "individual factor," the absolute necessity for early recognition of rheumatism becomes apparent. A well-nourished child in perfect health, under proper surroundings, will not harbor the infection of rheumatism; neither will a normal, healthy tonsil furnish an avenue for invasion. The important feature is the immediate recognition of any departure from the normal standard of health, to bear in mind that the function of the tonsil is more

active in early life, and calls for special attention, that growing pains are not of trivial importance, nor, on the other hand, should undue consideration be given them, and thus hinder the search for other causes, for they are not sufficient to explain all cases.

The treatment for the prevention and control of these cases is certainly rest. Rest is preventive and is curative. It means absence of muscular effort. It is not easily secured; in fact, it never is complete. In arthritic cases we can immobilize the affected joints and control them, but with the heart it is different. Its muscular action is unceasing with life, and we must be content with the soothing and quieting effect of rest and that obtained by remedies such as colchicin, cimicifuga, pulsatilla, rhus toxicodendron and spigelia. Diet, hygiene and nursing all have their place, and the indicated remedy holds a sphere of influence of no mean importance.

The earliest possible indication of heart involvement is the nervous phenomena, and an altered rhythm, with a quickened, tumultuous, uneven action, varying in individual cases present, even before the inflammation causes pericardial rubbing or distention. These latter two signs often appear together, not, however, in the very beginning, but two or three days later, for it takes time for the exudation to form and for the fluid to collect and distend the sac. Again, the pericardial rub is at times fleeting or fitful, and is only caught accidentally, thus calling for daily observation and consideration. The same holds true when searching for endocardial invasion. Here also the earliest indication rests with the nervous phenomena. Careful cardiac examination day by day will reveal a changeful character in the heart sounds and rhythm; and the earliest possible sign of endocarditis will be a tumultuous, quickened, uneven heart action. This is nothing in itself, but it is intensely suggestive in association with rheumatism, or where it is suspected. In many cases of rheumatic origin the endocardial murmurs will be precipitately established, and will leave no opportunity for prevention, while the sympathetic relationship between endo- and pericarditis is so closely intimate that the presence of one uncontrolled is strong proof of the oncome of the other.

With continued rest in bed in the treatment of these cases, remedies will prove of great service, and one of the most valu-

able where the rheumatic origin is existing is colchicin, which holds almost a specific action, and, if given before the cardiac involvement is established, pushing it to the limit of toleration, it will be found to be a preventive of excellent merit. Many are satisfied with the action of colchicum.

In cases presenting the tumultuous action and irregular rhythm in the early stage, especially if painful, spigelia will give good results. If it is not sufficient, iodine and spongia are to be considered. Cannabis is well indicated for apprehension, anxiety, with palpitation, and painful condition of the præcordium.

Bryonia is an old friend, especially useful before the oncome of effusion, while arsenicum is second to none for the established nervous symptoms, with suffocative attacks, violent, irregular palpitation, restlessness, anxiety, anguish, with cold surfaces and its endless train of symptoms.

Digitalis is claimed to be of service, particularly where there is effusion, but in these cases its value is overestimated or its application is faulty and useless.

In deliberating on the selection of remedies for endocardial inflammation, aconite is never to be forgotten, especially in the acute stages.

AN IMPROVED ALEXANDER OPERATION. (Goldspohn).—The operation consists essentially in cutting down on the ring, dilating it, and drawing forward the round ligament with its peritoneal attachments about the ring, including some of the muscular fibres, if necessary. The corpus uteri, ovaries and tubes are then examined and treated through the dilated ring. The wound is then closed by four layers of mostly continuous catgut sutures. The first suture is a purse string passed through the edges of the round ligament, the peritoneum and the dilated inguinal ring, and is then tied. The second tier of sutures anchors the round ligament broadly against the posterior surface of Poupart's ligament—an immovable object—and cushions it on a bed of elastic and vascular muscle tissue, which guards against strangulation. Hernia is made practically impossible by the mass of chiefly internal oblique muscle that is united also to the posterior surface of Poupart's ligament, and thereby strengthens the region of the internal inguinal ring and firmly closes the inguinal canal. The third row of sutures of the aponeurosis of the external oblique muscle, and the fourth the skin. The article is well illustrated. —*American Journal of Obstetrics*, May, 1900.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

THE RIGHTS OF THE HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

AGAIN we turn to the *Monthly Bulletin of the Rhode Island Board of Health*, referred to in our last, for a good starting-point for some thoughts on the above subject. We read there the remarks of Dr. Swartz of Rhode Island, a "regular": "The Rhode Island board is composed of two homœopathies (*sic*) and three regular practitioners, but the question of school has never come up in any way—not even in the form of difference of opinion in regard to questions in examinations. In fact, although the questions submitted in materia medica and therapeutics are of a character which would be considered as of the regular school, yet these questions have always been successfully answered, and sometimes more satisfactorily by those applicants which came from homœopathic schools."

There are several points of interest here which will repay closer consideration. In the first place, "the questions in materia medica and therapeutics are of a character which would be considered as of the regular school," although the board consists of two homœopaths as well as three "regulars," and were submitted to candidates, some of whom applied for licenses to practice as homœopathic physicians. But the question of school has never come up, "not even in the form of difference of opinion in regard to questions in examinations." Truly a state of millennial peace. The lamb is inside of the lion, and not a plaintive bleat betrays its presence. This is one of the inevitable consequences of a single mixed board of examiners, or perhaps it would be better to say "a single board of mixed examiners." We in Pennsylvania recognized the danger and avoided it. Peace at any price is often too dearly bought. Again, what value attaches to the certifi-

cate of such a board testifying to the fitness of the homœopathic candidates to practice homœopathy when, according to this, they have not been examined either in homœopathic materia medica or therapeutics? We do not know who the two "homœopathics" are, but that they are liberal in their views and quiet in their manners we cannot doubt. Their gentle acquiescence in what, to our minds, seems a rank injustice, is either worthy of all praise or of the strongest condemnation: of the first, if they see no difference between the materia medica and therapeutics as taught in the two schools, and have let this be known to the colleges whence the homœopathic candidates come for examination; but of the latter if this is not the case, and if they allow students instructed in homœopathic materia medica and therapeutics to be examined in these two branches by questions "which are of a character which would be considered as of the regular school." As we know absolutely nothing about these unobtrusive lambkins, and have intentionally refrained from looking up their names, antecedents and environments, our remarks can have no personal animus, but are directed solely against the principle illustrated by their action. They are either not homœopathic or are peace-at-any-price men, and in either case not fit to serve on a board which is to decide upon the fitness of graduates of homœopathic colleges to practice homœopathy.

This brings us to the third and last point, the facility with which these "regular" questions were answered by applicants coming from homœopathic colleges. "These questions have always been successfully answered, and sometimes more satisfactorily by those applicants who came from the homœopathic schools." We confess that here our argument of an injustice done seems to have run up against a snag. It seemingly was an injustice which did not work an injustice. Were there any evidence adduced that these homœopathic graduates were as capable of answering questions in our materia medica and therapeutics as they proved themselves to be in answering satisfactorily those of a "regular" character, we would shout *Vivant!* and would gladly enlarge upon the superior advantages offered by our homœopathic colleges to acquire a knowledge of medicine and therapeutics in all their aspects. Indeed, even with the doubt in which the matter is shrouded, we would

fain hope that such praise would not be altogether undeserved; but, alas! there is another side to the question.

Not knowing the homœopathic colleges of which the candidates for license were graduates, our remarks are again quite impersonal, and we cannot be accused of attacking any one in particular when we hesitatingly ask whether perhaps not more of "regular" than of homœopathic materia medica and therapeutics was given the students. That such might have been the case is a *possibility* which almost amounts to a *probability* when we consider the uniformly successful answering of those questions "of a regular character." As we have no means of deciding this point, we content ourselves with again drawing attention to the danger which threatens homœopathy from within. Homœopathy has no right to exist, except as a sect, if it cannot prove its claim to represent a distinct advance in therapeutics, based upon a materia medica peculiar to itself and governed by a scientific law. That part of the materia medica which is the common property of all schools must be taught in our colleges; but, unless its peculiar application to therapeutics according to our law be also taught, our colleges are not, and should not be called, homœopathic. We are then "trading upon a name," and rightfully expose ourselves to the charge of false pretences, so often brought against us. Let us teach "regular" therapeutics if we have time, but let it be by way of contrast and to show a better way. Our students have a right to demand of us homœopathic materia medica and therapeutics above everything; all else they can find in other institutions; and thither they will go if they do not receive from us what they had reason to expect. We often see our homœopathic therapeutics treated like a blue ribbon around a bulldog's neck. When there is no fighting the ribbon counts; when there is a battle on hand the ribbon is forgotten and the bulldog sails in.

Homœopathic therapeutics is something more than an ornamental frill on the motley garb of "regular" scientific medicine, and should be recognized in the questions asked even by a board of mixed medical examiners.

GLEANINGS.

THE THERAPEUTIC USES OF METHYLENE BLUE.—The *Lancet* (December 30, 1899) gave the following summary: Methylene blue administered in doses of 1 to 6 grains three times a day, owing to its recognized selective affinity for the nerve-cells and axis-cylinders in living animals, has proved of considerable value in such affections as sciatica, migraine, neuralgia and herpes. In diabetes mellitus methylene blue seems to act somewhat in the same manner as antipyrin. When given in full doses up to 6 grains three times a day during a period of six weeks, sugar has been found to disappear from the urine. Locally it diminishes the pain of cystitis and gonorrhœa, the urine being highly charged with the drug and acquiring a brilliant blue or green color when it is given internally. In cases of gonorrhœa complicated with rheumatism or neuritis it has proved of special advantage. In simple rheumatism the drug has been given with good effect, as it has in intermittent fever both in the acute stage and for the relief of the after-effects, such as enlargement of the liver and spleen. The general effects of the drug resemble those of antipyrin and salicylic acid. When given after food it excites little irritation in the stomach, the most notable feature at the time being the coloration of the urine, of which patients should be warned.

In *Merck's Archives* (February, 1900) Smithwick reports a series of fifty cases of different types of malaria, in all of which he administered methylene blue. These cases were not selected, but for a certain period every person whose blood showed the parasite was given the drug. All recovered except seven, and three of these refused to take the drug after the first two or three doses, while the four others were in a bad physical condition, and died in a short while from organic diseases. The usual dose was 2 grains six times daily, in pills or capsules. Of the fifty cases there were twenty-four of the quotidian type, fourteen of the tertian, three of the quartan, five of the estivo-autumnal, three of the hæmorrhagic and one of the double-quotidian type. In the hæmorrhagic cases methylene blue seemed to have a twofold effect—that of a parasiticide and diuretic. After its administration was begun the urine cleared up, and there was no return of the paroxysm. In all cases treatment was continued ten days after the last chill.

The author's conclusions are as follows:

1. Methylene blue is a perfect succedaneum for quinine, and may be given wherever the latter drug is indicated in the treatment of malaria of every form and under all conditions with the same confidence that has always attended the administration of quinine.

2. Patients need not be selected on account of idiosyncrasies, as no bad effects ever follow the use of methylene blue if given intelligently.

3. It is the remedy to use in malaria with hæmaturic complications, as it acts in a twofold manner.

4. It is the remedy to be given in malaria occurring during the pregnant period, as it has no oxytoxic effect, and will cause a freer action of the kidneys, which is also beneficial.

F. Mortimer Lawrence, M.D.

MALARIA AND THE MALARIAL PARASITE.—According to Manson, the pronounced and rapidly evolved anemia of malaria is due to the very large number of parasites found in the central circulation. The organism is not normally found, except in small numbers, in the peripheral circulation. The periodicity of the disease may be explained (1) by the habit of the parasite to live a more or less definite number of hours, and (2) by the diurnal rhythm in the periodicity of the physiologic processes of the human body.

There are three pathognomonic tests for malaria: (1) a periodicity of forty-eight or seventy-two hours; (2) the effect of quinine properly administered; and (3) the discovery of the parasite in the blood. A periodicity of twenty-four hours in the syndrome cannot be depended on in the diagnosis of malaria, since there are so many other conditions which present a quotidian periodicity. When there is an idiosyncrasy against quinine, methylene blue may be given in doses of 3 or 5 grains three or four times a day.—*Brit. Med. Journal*, July 21, 1900.

F. Mortimer Lawrence, M.D.

TREATMENT IN PERNICIOUS ANÆMIA.—Abrams, of San Francisco, formulates the following conclusions:

1. Arsenic is a true specific in pernicious anæmia, and is as certain in its immediate results as is mercury in syphilis, quinine in malaria, or iron in chlorosis. The specificity of arsenic is so great that in no case of grave anæmia are we justified in excluding the progressive pernicious variety, even though the blood examination is negative, without a heroic trial of arsenic. Like the other specifics, it produces relative cures, and cannot be regarded as a prophylactic, owing to the frequent relapses which occur. It may be given as Fowler's solution, beginning with 3-minim doses, well diluted, after each meal, and increased by 1 or 2 minims daily, according to the urgency of the case, until 25 or 30 minims are taken three times a day. A safer rule is to push it to the point of toleration and maintain it at this point until the blood examination shows the result desired. The appearance of its physiologic effects (œdema and itching of the eyelids, gastro-intestinal irritation, etc.) is a signal for its temporary discontinuance. When arsenic cannot be given by the stomach, it may be administered subcutaneously or even by the rectum.

2. In association with arsenic, assimilable food and rest are indispensable adjuvants.

3. The use of intestinal antiseptics in this, as well as in other diseases, is a mere therapeutic refinement not sanctioned by bacteriologic reasons, and they ought, therefore, not to be employed as a routine measure. In the Italian literature one finds some authentic evidence of the good effects from thymol, its administration being suggested by the theory that pernicious anæmia is caused by intestinal absorption of products which are destructive to the red blood-corpuscles.

4. Iron is not only useless, but is apt to create digestive disturbances.

5. Bone-marrow is said to be curative, but in the writer's experience it induces nausea and aggravates existing gastro-intestinal troubles.

6. Gastric disturbances suggest stomach lavage. The character of the food ingested must be determined by the results of chemical analyses of the stomach contents.

7. To counteract the great reduction in the quantity of blood (oligæmia), weak saline solutions may be given by the colon (enteroclysis) or preferably in the subcutaneous tissue (hypodermoclysis).

8. Relapses are best prevented by minute attention to dietetic and hygienic details.—*Gaillard's Med. Journal*, July, 1900.

F. Mortimer Lawrence, M.D.

EXPERIENCE WITH CARCINOMA OF THE LARGE INTESTINE.—Dr. I Boas gives us the results of his observations of fifteen cases, twelve men and three women, with carcinoma of the large intestine. In six it was situated in the cæcum or ileo-cæcal valve, twice in the right flexure, once in the left, once in the descending colon and four times in the sigmoid flexure. In only eight cases could a tumor be distinctly palpated, and in all these except one the growth was diagnosed and the condition was recognized. In the remaining seven, where no growth could be felt, the diagnosis was made; in four, in other ways. Subjectively the symptoms are varying, either be lacking or vague, or associated with increasing cachexia, which awakens suspicion of a malignant growth in an internal organ. Stenosing cancers as a rule present decided local symptoms, and on careful questioning one notes that until the beginning of the illness there was a wholly normal function of the lower bowel, or possibly a mild degree of constipation. The condition began suddenly without apparent cause, with more or less severe signs of stenosis of the intestine, accompanied by violent colicky pains, nausea and vomiting. After a more or less copious evacuation the symptoms disappear, to reappear at shorter intervals and in greater intensity until they remain permanent. The vomiting becomes more frequent and copious. To these symptoms are added the signs of a malignant neoplasm, and even if subjective symptoms are lacking a cancer coli may be diagnosed with all probability. In cases where it is situated in the lowest part of the sigmoid flexure, rectal tenesmus, or even that of the bladder, may be an accompaniment.

In some patients signs of ileus suddenly become apparent, though they have seemingly been in good health and have presented symptoms of no consequence. In some of these an indiscretion in diet may be that which leads to a diagnosis of intestinal stenosis, and on questioning it may be learned that for weeks or months slighter attacks of ileus have been experienced.

More certain, of course, a tumor with the characteristic signs of intestinal growths; passive mobility and spontaneous change of position is diagnostic. Yet not all colon tumors possess this peculiarity, for out of eight cases with a decidedly palpable tumor these characteristics were noted in two, which, curiously enough, were seated in the least moveable portion of the large intestine, the cæcum. In some cases the growth may be palpable one day and not to be felt the next. Inflation of the colon is of service to differentiate from retro-peritoneal tumors and to test as to the mobility. It is very difficult to distinguish malignant from benign growths or inflammatory exudates, and particularly tuberculous growths of the cæcum. In some cases the age, duration of the disease, and other possible tuberculous manifestations, the demonstration of tubercle bacilli in the fæces, while in still others the

necropsy will only decide. In some, possibly, the diazo-reaction may be of service, for it is said wholly to be lacking in intestinal carcinoma, while it is nearly always present in tuberculosis of the intestine.

Constipation, which may alternate with diarrhoea with paroxysmally appearing attacks of colicky pain, is the most important of the symptoms of stenosis; objectively, meteorism and the palpable contraction of the section of intestine above the stricture—"the Darmsteifung" of Nothnagel—are noted. The latter alone is characteristic. If a tumor be not palpable it is difficult to locate the site of the growth. In some cases examination per vaginam during the pains has enabled him to feel a distended loop of intestine in the true pelvis, which may safely be assumed to be colic of *small* intestine. If there be no contraction above the stricture during the intervals, a splashing of liquid in the dilated gut may be of diagnostic value.

The vomiting is reflex, and the manner of vomiting should be noted to distinguish it from that of stomach diseases. It may contain hydrochloric acid and biliary constituents or not; it is rarely fecal and has nothing characteristic. In two cases there was violent hæmatemesis, which comes from ulcers in the dilated portion of intestine, and antiperistaltically is vomited. In only one case was HCl absent from the gastric contents; this may be of service in obscure cases to differentiate malignant growths of the stomach.

The stools may be normal, more or less constipated, diarrhoeic, or alternately diarrhoeic and constipated; the so-called stool of stricture, the small-calibred stools, are of no value unless the stricture be in the lowermost portion of the colon. Admixture of pus or blood he has not noted frequently, and that in slight quantity. If a tumor be absent, one should not be too hasty in concluding from the presence of blood or pus in the stools that a malignant neoplasm is present, for it may be due to ulcerous colitis, perforating para-intestinal abscesses, chronic dysentery and chronic intussusception. In one case where the ascending colon was affected pseudomembranous enteritis was noted. As this condition has colicky pains, emaciation and serious constipation, it might mislead. Particles of tumor in the stools he has never observed.

The general condition is seriously affected, but in a few patients there is neither emaciation, cachexia nor loss of weight; in others there may be alternating loss and gain in weight. As to treatment, he advises against such food as asparagus and Graham bread, which make bulky stools. A diet rich in fat does best. Mild laxatives act well. If there be "Darmsteifung" opiates are required, which not only sedate, but they are also the best laxative. Surgically something may be done, though the prospect is not encouraging. The requirements are an easily movable tumor, assumedly of a carcinomatous nature, in a patient whose general condition is still good.—*Hospitalstidende*, No. 13, 1900.—(Last year I had a case of carcinoma of the pylorus under observation where the tumor, which was very easily palpable, could be pushed across the abdomen and somewhat downwards; the vomiting had come on quite late, and was not so very pronounced. Those features, together with the late failure of the patient's strength and the earlier and very chronic history of stomach symptoms, led to a diagnosis of intestinal cancer by my consultant, whose opinion I much regard.)

Frank H. Pritchard, M.D.

HÆMATURIA (Hazen, Virginia).—The interesting condition which we know as hæmaturia is, of course, only a symptom, but is worthy of discussion because it frequently rises to considerable dignity on account either of difficulty of diagnosis or treatment, or because of the unfavorable prognosis rendered necessary by the grave conditions which constitute its etiology.

(a) Hæmaturia due to conditions lying within the urinary tract.

(b) Hæmaturia, including hæmoglobinuria, due to conditions outside the urinary tract.

Class A.

1. Traumatism to urethra, prostate gland, bladder, ureters, pelvis or substance of kidney.

2. Injury to the mucous membrane by parasites.

3. The effect of certain drugs.

4. Disease: Urethritis, prostatitis, cystitis, ureteral or renal inflammation.

5. Stone in bladder or kidney.

6. Morbid growths, benign or malignant; urethral polypus; syphiloma tubercle.

7. Congestion from cardiac disease.

Class B.

1. Secondary degeneration from tuberculosis and syphilis.

2. Dyscrasia and cachexia due to cancer of other organs.

3. Dyscrasia and cachexia due to infectious diseases.

4. Dyscrasia and cachexia due to purpura, scurvy, malaria.

Treatment of the first class will be to remove the local cause, and of the second class directed toward the underlying constitutional condition.—*Charlotte Med. Journal*, June.

Herbert P. Leopold, M.D.

THE TREATMENT OF SYPHILIS (Carleton, New York).—During the early period of the disease, nothing should be permitted to reduce the general vitality of the patient. Special attention must be paid to the amount of sleep, massage, hot-baths, douches, special exercise, change of climate, during the entire duration of the disease. Tobacco should be prohibited. Alcoholic beverages and sweets to be taken moderately, diet regulated, and teeth put in good condition and kept so by proper care. When mercury is given in any form, acids must be interdicted.

The chancre must never be cauterized. It should be carefully cleaned with antiseptic solutions and dusted with bismuth subnitrate, zinc oxide, iodoform or aristol. In the female, frequent douching with the bichloride of mercury, 1 to 3000, and the application of gray plaster will be of benefit. Often the original lesion will not disappear until the treatment for the general secondary conditions is well under way.

In the primary stage mercury rarely, if ever, is indicated. Corallium rub. is the most useful. For the secondary lesion, *i.e.*, the erythematous, papular or pustular syphilides, and their associated involvement of the mucous membrane, mercury is generally indicated, as well as in the breaking down of gummatous masses and ulcers in the tertiary stage.

It is best given in inunctions, in combination with a neutral soap. By first wetting the surface, and adding a few drops while rubbing, it usually disappears in from fifteen to twenty minutes, and leaves the skin clean and dry.

Potass. iod. is indicated in the so-called third stage, in increasing doses,

though in neglected cases it will not act satisfactorily unless preceded by a few mercurial inunctions. "It must be given in the largest dose to remove the gumma; the size of the dose is immaterial."—*Medical Times*.

Herbert P. Leopold, M.D.

SIPHONAGE OF THE PARTITIONED BLADDER FOR THE INDIVIDUAL KIDNEY URINES.—Downes (Philadelphia) presents a new instrument for the collection of the separate urines which he calls the "Separate-Urine Siphon." It is a modification of the Harris segregator, in that the suction apparatus is dispensed with, and the instrument further simplified in other ways. It is made of two parts—a double-barrelled bifurcating catheter of small calibre (13 American scale), and a partition-rod which elevates the bladder-wall between the catheter ends for fully $2\frac{1}{2}$ inches. The rod differs for the sexes, and is attached to the end of the shank of the catheter by a small fixed clamp and thumbscrew. Movement of the beaks during introduction of the instrument into the bladder is prevented by a little fixation-pin.

The technique of using the instrument is much the same as that of the Harris segregator. Compared to the latter instrument we note the following differences: A much smaller calibre as a whole. A simpler curve at the beak end. A longer and more certain bladder-partition. One definite fixed relation between the beaks and the partitioning medium. The absence of all unnecessary suction apparatus. The absence of a spring for elevating the partition. The introduction of a new feature, siphonage alone, for the withdrawal of the individual kidney urine. The author has used the siphon with universal success in eight cases. One was an old man with an enlarged prostate, in whom he succeeded in obtaining his individual urine with little or no distress to him for thirty-five minutes.—*Philadelphia Medical Journal*, June, 1900.

Gustave A. Van Lennep, M.D.

PERMANENT (CONGENITAL) DISLOCATION OF THE PATELLA.—McLaren (Edinburgh) reports the following case which came under his care at the Royal Infirmary:

A girl, nineteen years of age, with a congenital dislocation of the patella of the left leg. Marked genu valgum, and rotation of the leg outward. "When the knee is extended the patella lies somewhat to the outside of the normal position. When the joint is flexed it passes farther and farther outward, till it lies on the outer side of the external condyle of the femur. The fossa patella of the trochlear surface of the femur can be felt to be partially filled up, as it were, on its outer side, as if the external condyle projected into it, while the outer edge of that condyle, on the other hand, seems to fail altogether and leave a gap under the outer edge of the patella."

The genu valgum was first corrected by an osteotomy, and three months later the patella was fixed in its proper position by a second operation. An U-shaped incision was made over the knee, and the flap of skin turned up. The capsule on the outer side was divided, with the expansion of the quadriceps tendon, but without opening the cavity of the joint. This freed the patella so that it could be easily brought to the middle line, and it was stitched into position by means of catgut sutures passed through drill-holes on its inner aspect and the internal lateral ligament. The wound healed kindly, but a relapse took place, owing to too rapid absorption of the suture

material. The operation was performed over again about eight weeks later, substituting silk for the catgut sutures. The result, four years after the operation, was perfect. The patella retains its normal position, and the patient walks and runs with ease.

Other methods of treatment for this condition are: Detaching the ligamentum patella and nailing it farther inward to the tibia (Roux). Detaching the tubercle of the tibia and nailing it farther inward (Goldthwait). Opening the joint, cutting a groove on the surface of the femur, and fixing the patella in it by suture. (Lucas Championnière). Division of the insertion of the vastus externus through an external incision; chiseling out a groove in the cartilage and bone of the femur through an internal incision, and placing the patella in this (Bilton Pollard). These procedures are much more severe than that practiced by the author, and should be reserved for those cases that will not yield to the simpler method.—*Annals of Surgery*, June, 1900.

Gustave A. Van Lennep, M.D.

REMARKS ON VASECTOMY RELATIVE TO ENLARGED PROSTATE AND BLADDER ATONY.—Reginald Harrison (England) says: "It has been extremely interesting to follow the various communications that have been made during the last few years relative to the employment of vasectomy and castration in the treatment of prostatic hypertrophy. In some cases the results have been admirable, in others doubtful, whilst between these two extremes there have been various gradations. In my own practice, since my advocacy of vasectomy in 1893, I have performed the operation in over 100 cases, and I can say that whatever effects were exercised upon the prostate, I have never seen any harm result or heard of any regret expressed from what followed, other than that arising in a few instances from failure to obtain by comparison all the good that might have been anticipated."

The author further demonstrates from personal research "(1) that the usual effect of vasectomy is to induce shrinkage of the hypertrophied prostate; (2) that though this shrinkage affords a readier access to the bladder for catheters and such like purposes, it did not necessarily follow that voluntary and natural micturition was thereby restored, failure in this respect being mostly due to structural changes in the bladder itself arising out of long-continued obstruction; and (3) that the latter consists of certain kinds and degrees of sacculation, pouching and trabeculation of the bladder, whereby its voluntary expulsive power is permanently and frequently irrecoverably damaged."

The operation of vasectomy is further modified as follows: A small incision over the duct is made, the isolated vas seized with a pair of "Spencer Wells forceps," and a small portion of it is tossed out. No ligature is used. The wound is closed and sealed with collodion on gauze. A week or ten days' interval in dealing with the two vasa is advised. The author prefers this operation to castration for the reason that the latter extinguishes sexual power, whilst vasectomy does not appear to do so, though it obliterates the seminal ducts.—*The Lancet*, May, 1900.

Gustave A. Van Lennep, M.D.

REMOTE RESULTS OF CONSERVATIVE OPERATIONS ON THE OVARIES AND TUBES (Burrage).—The writer draws the following conclusions based on his observations of 137 cases:

1. It is advisable to do conservative operations in all cases where the ovaries and tubes are not hopelessly diseased in all parts of their structure,

except on patients who are near the menopause, on patients who have pronounced gonorrhœa of long standing, and on the rare cases of malignant disease.

2. When a patient is over thirty-five years of age and has ovarian or tubal disease of any considerable degree of severity, it is generally wiser to perform complete removal, with or without hysterectomy, according as the uterus also is diseased or not.

3. In cases of well-marked gonorrhœa of long standing, especially if the patient is constantly exposed to reinfection, if both tubes are seriously diseased and closed, total removal with or without hysterectomy is the operation of choice.

4. In certain cases of this class, when the patient thoroughly understands the likelihood that another operation may be necessary at some future time, and wishes to take the chances in the hope of preserving the function of menstruation, conservative operation is permissible.

5. If one tube is patent and healthy in appearance, and there is enough healthy ovarian tissue to preserve, a conservative operation ought to be performed even in the presence of gonorrhœa.

6. With present methods of performing resection of the tubes, if both tubes are found closed at the time of operation subsequent pregnancy is not to be expected.

7. In severe grades of inflammation of the appendages, irrespective of causation, if the ostium abdominale of one tube is patent, the prospect of subsequent pregnancy after the preservation of a portion of ovary is about one in four and a quarter, or $23\frac{1}{2}$ per cent.

8. In the less severe grades of inflammation, under similar conditions of tubes and ovary, the prospect of subsequent pregnancy may be expected in 35 per cent., whereas in the previous sterile it may be looked for in only 5 per cent.

9. If it is necessary to remove both ovaries it is of no advantage to preserve any portion of tubal tissue; but, except under the conditions just enumerated, some ovarian tissue should be preserved in every case.—*Amer. Journal of Obst. and Gyn.*, August, 1900.

George R. Southwick, M.D.

PATHOGENIC BLASTOMYCETEN AND THE ÆTIOLOGY OF CANCER (G. Leopold).—The writer uses a microscope of special construction with a warm stage, and in many examinations of hundreds of specimens of cancer from all parts of the body finds blastomyceten always present. He examines by preference specimens beyond the areas of degenerated structure, and where the margins or outposts, as it were, of the cancer are invading the organism. He has established, in one instance, the following chain of evidence:

1. Blastomycetes were found in a fresh carcinoma of the ovary of a woman.
2. Blastomycetes were obtained in a pure culture from this fresh carcinomatous tissue.

3. This pure culture injected in the testicles of a rat caused in the latter a large number of peritoneal nodules, which caused the death of the rat, and in both fresh and hardened specimens of the tissue quantities of blastomycetes were found.

4. Pure cultures of blastomycetes were obtained from these nodules.—*Archiv für Gynakologie*, Bd. 61, H. 1, 1900.

George R. Southwick, M.D.

THE USE OF FORMALIN IN PUERPERAL ENDOMETRITIS. (Fell.)—The case was one of puerperal fever following craniotomy. In spite of uterine irrigation and the removal of suppurating masses, *i.e.*, sloughs, the temperature sank but little, and the condition of the patient became more and more hopeless. The vagina was now tamponed loosely with gauze wet in a solution of formalin 4:180. It was allowed to remain twelve hours, and caused no pain except slight burning. The fever and other symptoms of sepsis then diminished.—*Centralblatt für Gynäkologie*, No. 19, 1900.

George R. Southwick, M.D.

MYOMECTOMY DURING THE SIXTH MONTH OF PREGNANCY; RECOVERY.—Lewis, Kansas City, Mo., reports the following rare case: The patient, 27 years of age, primipara, was seen by him in November, 1899. He says:

"The uterus was in the sixth month of gestation, and the tumor, as large as a large orange, was situated superior and anterior to the tube on the right side. An incision in the linea alba, about nine inches in length, was made to allow the extrusion of the entire gravid uterus and its appendages. The tumor did not involve the Fallopian tube, but projected out from the uterus like a large knot on a log. The serious complications liable to arise from an effort to remove the solid fibroid tumor were not underestimated, but were well considered. The rapidly failing health of the patient, the great distention of the abdomen, in fact, the congeries of conditions present in the case, were rather dazzling, but the relief of the patient was imperative; something had to be done, and as instantaneously as possible. A mistake in diagnosis led to the operation, as the tumor was supposed to be occupying the tube, and not connected at all with the uterus proper. The child could be plainly felt in motion beneath the thin walls beyond the growth. Realizing the situation, the question was hurriedly raised as to a complete hysterectomy, but as the operations of that character within our knowledge and experience had all proved fatal at this advanced stage of pregnancy, it was interdicted; so but one of two things remained for us to do instantly, either return the entire mass and try to close the abdomen, or try to remove the growth from the wall of the uterus and return what was left. I at once made an incision over the dense growth, about five or six inches in length, in the uterine muscle wall, and quite rapidly hulled out the tumor, leaving free hæmorrhage to contend with at a limited area of the surface exposed. Very deep sutures were used to control the bleeding, and the opening in the uterus was closed with interrupted sutures; over the outside of this closed incision I laid a strip of iodoform gauze, one end of which I left exposed in closing the abdominal incision. The fourth day I removed this gauze and on the twenty-fifth she was allowed to go to her home, forty-five or fifty miles distant. She was confined at full term, March 11, 1900, just three and a half months after the operation. Her attending physician wrote that mother and child were doing well, and that delivery was made without forceps, the use of which I had advised for fear of a rupture of the organ in a prolonged labor.

"One point I wish to call attention to, in regard to the relation of the placenta to the tumor, *viz.*: the placenta seemed to have its attachment immediately beneath the growth, for on all other parts the uterus seemed as thin and yielding as a bladder."—*Am. Journal Surg. and Gynec.*, September, 1900.

W. D. Carter, M.D.

THE EXTRACT OF SUPRARENAL CAPSULE IN OCULAR THERAPEUTICS.—On account of its powerful vaso-constrictor action, the author has found this drug to be of much service, both from a diagnostic and a therapeutic standpoint. As it blanches the conjunctiva before it does the deeper structures, it is valuable in diagnosing between a conjunctivitis and a scleritis or iritis. Between the latter two diseases there is the additional distinction that the injection in the case of scleritis disappears irregularly, whereas the pericorneal zone of iritis fades out evenly.

As is well known, intense injection of the conjunctiva renders the absorption of cocaine extremely slow. This lack of action may be overcome by alternating instillations of cocaine with aqueous solutions of the drug. Certain cases of glaucoma also yield much more quickly to the effects of myotics if these drugs are employed in combination with this drug.—Darier, Paris.—*La Clinique Ophthalmologique*.

William Spencer, M.D.

PHOTOTHERAPY IN OPHTHALMOLOGY.—The author employed phototherapy in a number of eye diseases, *e.g.*, in chronic keratitis, chronic iritis with opacities in the vitreous, chronic choroiditis, and in chronic retinitis, after the usual modes of treatment had proved useless. He constructed for that purpose a special light-box with 1375 candle-power. The patient remains in this light-box for 5 to 20 minutes, and he is exposed to a temperature of 30° to 80° C. The eyes should be covered with a bandage or with dark glasses; the head is covered with a moistened bandage, which is frequently changed.

Acute cases, photophobia, habitus apoplecticus and diseases of the heart are contra-indications to this treatment. During and after light-bath the condition of the patient must be closely watched by the attending physician (auscultation of the heart, cool bath after the light-bath, etc.). The author is of the opinion that the light-bath is a stronger resorbent than the steam-bath, which is also used for the same purpose.—Doxenberg.—*Wiener Medicinische Presse*.

William Spencer, M.D.

TUBERCULOSIS OF THE CONJUNCTIVA.—Three cases of tuberculosis of the conjunctiva are reported by Viensse; all occurred in young girls. Two of the patients suffered from lupus of the face. Two were successfully treated by complete removal of the diseased portions, followed by scraping and cauterization of the face. Iodoform was dusted over the exposed surface, and the eye was closed with a bandage for a few days' time.

The surface that was cauterized several times healed with a firm scar. In no case was there symblepharon or entropion. The author divides the types in which the disease may appear under three classes.

In the first there is swelling of the conjunctiva, which has a bluish-red color in association with a deeply-excavated ulcer with ragged edges. In the second form of the disease almost all of the surface of the palpebral conjunctiva is covered with slight excrescences, the tips of which are frequently ulcerated. The third variety constitutes the polypus form. This is rare. The author is of the opinion that the disease frequently commences in the nose and spreads from thence to the conjunctiva. Consequently he believes that the nasal cavities should always be examined.—Viensse.—*Recueil d'Ophthalmologie*.

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

METHYLENE BLUE AS A REMEDY.—Halbert, of Chicago, states that methylene blue was first called to his attention by Dr. Clarence Bartlett, of Philadelphia, who had used it successfully in neurological cases of various kinds. Halbert attempted to use it in the graver forms of nervous disease, especially *tabes dorsalis*, but was at first much disappointed in its effects, although he thinks that he had some success in cases of *paralysis agitans* and multiple sclerosis. Nevertheless, he continued his investigations, and was finally rewarded by some degree of success in the neuralgias of *neurasthenia*. One of these cases he reports in detail: a *neurasthenic* woman who for a long time had been given morphine and other hypnotics every night because of severe facial neuralgia. She had been operated upon for carcinoma of the breast, and there was evidence of organic involvement of the other breast and the mediastinum. Methylene blue was given in the third attenuation four times daily, with relief in a few days. Further use of the remedy in similar cases has given very encouraging results. The tendency to tremor in *neurasthenia* and the spasticity of hysterical contractures is certainly overcome, and Halbert believes that the remedy lessens the irregular innervations of exhausted nerve-cells, and corrects the trophic disturbances which appear as the result of nervous exhaustion. He has also tried the remedy, with pronounced improvement, in cases of spinal irritation; and at present he is trying it in chorea and epilepsy. In one case of transverse myelitis he sees encouragement from its use.

In malarial fever we cannot find a better remedy. It destroys the *plasmodium malariae* better than quinine, and the after results are better. He believes that in typhoid fever we shall find nothing better, and the favorable results in four cases mentioned would seem to justify that belief.

In cases of pus infection it cannot be equalled. It has already made a record in gonorrhœa and cystitis. In prostatitis and pyelitis, or in any condition where pus is present, its efficacy cannot be doubted. In cases of simple albuminuria, where prostatitis or cystitis are complicating factors, it has worked like a charm.

So far as any bad effects are concerned, he has as yet observed none. Other than the discoloration of the tongue and the "blueness" of the urine, no unfavorable symptoms ever appear. Herter claims that it may be successfully used as a test for the ability or inability of the kidney to do its normal excretory work. In other words, a prompt disappearance of the dye within thirty-six hours may be taken as an indication that the kidneys are normally relieving the blood of urea, salts and other urinary constituents. A delay

in this respect would indicate a latent uræmia. In the latter condition it is quite probable that the remedy should not be used.—*Clinique*, August 15, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF HAY FEVER.—In addition to local measures and attention to diathetic conditions, Smith, of Chicago, recommends the following internal remedies :

Arsenicum iod. is as nearly a remedial specific as we possess ; especially indicated in pale anæmic patients with glandular enlargements. The mucous surfaces itch, and the discharges therefrom are excoriating. Marked prostration, great restlessness and anxiety complete the affliction.

Chin. ars.—More often indicated in malarial districts, and characterized by suffocative attacks, beginning about midnight and lasting until morning, compelling the patient to sit up and lean well forward.

Naphthalin 2x is indicated in those cases complicated with asthma, and for such is almost specific. Much puffiness of the face and discomfort, if not actual pain, in the frontal region are reliable indications.

Allium cepa is an accredited prophylactic with which the writer has had no experience. All symptoms are aggravated upon entering a warm room, and relieved by cold air.

Aralia racemosa is said by Dr. Veschlage, of New York, to be indicated if the patient exhibits extreme sensitiveness to a draft, the least current of air causing sneezing, with copious, watery, excoriating discharge from nostrils and posterior nares of a salty acrid taste.

Rosa d. 6x the late Dr. Ivins found to act prophylactically and curatively in the spring forms of hay fever.

Sanguinaria can. has for special indications susceptibility to odors which sometimes cause faintness ; raw, scalded feeling of nasal mucous membranes and a right-sided aggravation of all symptoms.

The writer has seen no results from such remedies as *artemisia euphrasia*, *sabadilla*, *sinnapis* or *sticta*. Occasionally the familiar general symptoms of *gelsemium*, *nux vomica*, *phosphorus* or *zincum* are present. Theoretically, material doses of *ipæcac tr.* or *1x* should prove beneficial, if not curative, and he intends to give it a trial.—*Clinique*, August 15, 1900.

F. Mortimer Lawrence, M.D.

OPIUM AS A PURGATIVE.—A writer in the *Boston Medical and Surgical Journal* (August 16, 1900) reports the case of a boy aged five years who swallowed a quantity of cheese suddenly, in order to escape detection. From that time on, he had intestinal obstruction, which was believed to be due to the cheese lodged at the ileocaecal valve. Various laxatives and purgatives failed, and an operation was considered. Fortunately, a consultant advised the employment of opium, which "apparently relaxed the spasms and caused free purgation."

F. Mortimer Lawrence, M.D.

DEADLY ACETANILID.—The editor of the *Eclectic Medical Gleaner* (August, 1900) states that the greater his experience, the stronger his conviction that acetanilid is a bad drug, and a very bad one at that. There might possibly be an excuse for using a single small dose to relieve a nervous headache ; but repeated dosage as an antipyretic is a most dangerous practice. Though its

depressing effects may not be seen in its usual cyanotic manifestations, so carefully described under its "physiological" action in the therapeutic classics of the day, they are certain to be seen in the depressed heart action that shows itself about the tenth or fourteenth day. The writer once heard Prof. J. A. Jeancon say that "two grains of acetanilid make a big dose for anybody at any time," and experience compels the statement that two grains given to a case of hyperpyrexia many times will produce dire effects upon the heart. No drug should be prescribed simply as an antipyretic.

F. Mortimer Lawrence, M.D.

LOBELIA FOR VOMITING.—Recently the action of the small dose pleased us and a patient whom we were called to see for the first time. A lady had been subject to spells of vomiting for a year or more. Usually they lasted two or three days, and when they ceased she was very weak and exhausted. Upon this occasion the indications for lobelia never seemed to be more marked. Ten drops of the specific medicine were added to four ounces of water, and she was directed to take a teaspoonful of the mixture every half hour until better. She was also directed to lie down, keep very quiet, and to abstain from food and drink until the stomach righted itself and demanded it. We left her confident that she would be better.

Upon our return next day, she said she had vomited but once, and that she felt as though she could eat a good meal, and truly she looked it. We cautioned her to be careful, and changed the prescription to specific nux vomica, which she has been taking three or four times a day since, and there has been no return of the emesis. She eats well; sleeps well; looks well—is well.

She said to me, "Doctor, what was that you gave me to check vomiting?" We replied, "Lobelia." "Why," said she, "I thought lobelia was given to produce vomiting." We replied, "So it is, but in small doses it checks it." The emetic effect is its physiological, so-called, its poisonous effect. The other is its medicinal action.—*Eclectic Med. Gleaner*, August, 1900.

F. Mortimer Lawrence, M.D.

THE CLINICAL USE OF THE IODIDE OF ARSENIC.—Blackwood, of Chicago, characterizes the iodide of arsenic patient as chilly; he cannot endure cold weather, and his family history reveals a tendency to tuberculosis. Whenever he develops a bronchitis or pneumonia, the process is apt to terminate in tuberculosis. In diseases of the skin it is of service when there is a dry, scaly eruption, attended with persistent itching. From the mucous membrane of the nose it produces a thin, watery, irritating and excoriating discharge from both the anterior and posterior nares, and a fluid, acid coryza with paroxysms of sneezing, which are worse in the open air. The patient is pale, anæmic and prostrated, and is subject to asthmatic attacks. There is a feeling of weakness in the eyes with burning pain, as if lachrymation would appear. From these symptoms it is evident that it will be demanded in hay fever.

It is just as serviceable in chronic nasal catarrh. The nose is swollen, there is a profuse thick yellow discharge, with destruction of the mucous membrane to such an extent that ulcers are formed. The discharge is excoriating, there is burning in the pharynx, and the tonsils are enlarged. In the mouth it produces a thick membrane that extends from the fauces to the lips; the

breath is fetid, the respirations are difficult, the pulse is slow and weak, and there is great prostration. From these symptoms its similarity to diphtheria may be seen, and while the symptoms resemble those of arsenicum alb., there is more glandular involvement with the iodide.

It is indicated in both hypertrophic and follicular pharyngitis where the nasal discharge is watery and excoriating; there is prostration, and one is in doubt whether there is tuberculosis developing or not. Should the disease be located lower in the respiratory tract, the respirations are increased in frequency even while at rest. There are attacks of asthma, which cause the patient to sit up in bed. Following a slight bronchitis or pneumonia, there is a tendency to develop tuberculosis; and you will find it indicated in cases of bronchitis which are associated with pulmonary tuberculosis in the early stages, where there is pallor, rapid loss of flesh, anæmia and dyspnœa.

Iodide of arsenic acts favorably when degeneration involves the heart and larger arteries, and also in cases of senile heart where the organ is enlarged, its action irregular and increased, the pulse has a hard feeling under the finger, and there may be slight anginal pains at times. In several cases these favorable results have followed its use where emphysema of the lungs was associated with a diseased heart. When the degenerative process invades the kidney and a chronic interstitial nephritis results, this remedy, while not curative, stops the process and restores the drooping vitality.

Dr. Blackwood refers to numerous clinical cases which illustrate these therapeutic activities of arsenic iodide.—*Clinique*, August, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF DIARRHŒA.—A writer in the *Eclectic Medical Gleaner* (August, 1900) does not hesitate to refer to the remedies ordinarily used in diarrhœa—opium, acetate of lead, kino, chalk mixture, tannic acid, etc.—as “horrible stuff.” Yet, to a man who has been taught such medication, it requires no little confidence to trust a severe case of diarrhœa to seven or eight drops of specific nux vomica in four fluid ounces of water—a teaspoonful of the mixture every half hour or hour. Yet when the tongue is broad, pale, flabby, clean, and there are gripy pains about the umbilicus, the patient needs no other medicine than nux. When the tongue is reddened at the tip and edges (irritation of the sympathetic), he advises small doses of ipecac. In either case, if there be frontal headache, rhus tox. may be alternated. He believes that there is little need of opiates at any time; they are positively contraindicated when the intestinal tract contains decomposing matter; and even in cases where the tract is clean and the stools are large, watery and frequent, with severe nagging or griping pain, it is better to give small doses of colocynth.

F. Mortimer Lawrence, M.D.

IODIDE OF ARSENIC IN HAY FEVER.—Chandler, of Salt Lake City, commends the use of iodide of arsenic 3x, two or three grains every two or three hours, in hay fever. It will relieve the majority of cases readily; surely, if you find the burning, irritating character of discharges from nose, throat or eyes, the specific indications for arsenic. Catarrhal sore throats and catarrhal conditions generally will be quickly relieved by iodide of arsenic when these indications are present.—*Eclectic Med. Gleaner*, August, 1900.

F. Mortimer Lawrence, M.D.

THE HAHNEMANNIAN MONTHLY.

NOVEMBER, 1900.

THE MANAGEMENT OF THE INTESTINES IN ABDOMINAL OPERATIONS.

BY HOMER I. OSTROM, M.D., NEW YORK.

(Read before the Surgical and Gynæcological Association, Washington, D. C., June 18, 1900.)

ABDOMINAL surgeons have been slow to realize that the surgical law, *rest*, does not apply with the same force in their department of operative surgery as it does in other and more general operative work.

If a limb is broken, if a joint is injured, or if the eye is operated upon, rest is a most important element in the cure, and is considered quite essential to the restoration of the function of the part. If the brain is tired, it must cease working. If muscles have been overtaxed, they must rest, or their power of contraction will be permanently lost. Surgical rest, therefore, seems to be of quite general application, but exceptions are noted in abdominal operations. Formerly it was thought necessary to keep patients who had undergone abdominal operations absolutely quiet. They must not be allowed to move, or to be moved, for twenty-four hours. The intestines were kept inactive for a varying length of time after the operation; the stomach remained empty, and the patient was deprived of water, thus insuring rest to the kidneys.

Of recent years we have applied physiological laws to abdominal surgery, with the result of more liberal and rational treatment during convalescence, and a lower mortality rate. These physiological laws have to do with the functional activity

of the organs upon which the system depends for its support; and if we consider the organs operated upon, and more or less involved in a laparotomy, we cannot fail to find an explanation of the benefits following a system of treatment that favors and encourages a continuance of functional activity after abdominal operations.

The abdominal organs, as distinct from the pelvic organs, are essential to life, in that their function eliminates some effete material, the result of metabolism, from the system. The arrest of the function of an eliminating organ is followed by the storing up in the system of the poison that should be removed, and for the removal of which nature has provided ample means. If, therefore, we would follow the suggestions of nature, we cannot, with impunity, arrest a function that she has established as essential to the well-being of the organism. Hence, the surgical law, *rest*, must give place to the physiological law, *functional activity*, in abdominal surgery. Under the application of this law our treatment before, during and after an abdominal operation, favors the continuance of the functions of the intestines, the liver, the kidneys and the peritonæum. I place the peritonæum in the list of abdominal organs, because, as a great lymph organ, it is second in importance to none as a secreting and eliminating surface. Not only does it secrete the fluid that keeps the different organs apart, but it disposes of noxious materials and organisms, to such an extent as to place it among the most important protective organs of the system.

At this time I will ask your attention to a consideration of the management of the intestines in abdominal operations, believing that upon their successful manipulation depends the favorable termination of the operation.

The discussion of the subject naturally falls under three heads: 1. The management of the intestines before the operation. 2. The management during the operation. 3. The management after the operation.

If proper attention is given to the intestines before the operation, they will require little attention after the operation. By proper attention, I mean thorough cleansing, and rendering them aseptic. The former I accomplish by means of cathartics, and diet. When time will allow, I give German liquorice powder two nights before the operation, and follow this with

enemas the next day, and on the morning of the operation. The diet is largely animal for twenty-four hours preceding the operation, and I instruct my nurses to encourage the patients to drink as much water as possible.

The aseptic condition of the intestines before an abdominal operation I consider of the utmost importance. In health, under ordinary conditions, the system can take care of any sepsis in the intestinal canal that may be the result of changes in its contents, but under the conditions of depression and shock that belong to abdominal operations—and in this connection it must be remembered that nature in her plan did not contemplate laparotomies, or their results—it is not able to do so, and we must offer our assistance. For the purpose of intestinal asepsis I use “Guaiaicol,” giving a tablet, $7\frac{1}{2}$ grains, three times a day for several days preceding the operation.

Whether or not I give a cathartic immediately before the anæsthetic depends upon the habit of the patient, as well as the disease for which the operation is done.

If constipation is the habit, or if the case is septic, I frequently give a dose of Epsom salts about two hours before that set for the operation, which usually insures the free passage of gas and fecal matter within twelve hours. This accomplished, we are relieved from much anxiety.

I have been criticised for using calomel (possibly the critic did not know that the homœopathic name for calomel is *merc. dulc.*), Epsom salts and liquorice powder in my abdominal surgery, and one professional brother ran so far off the mark as to say that I bound up my patients with morphine, and then used calomel to unbind them. This gentleman, self-confessed, had had no experience in the treatment of abdominal cases, and therefore his opinion deserves no more attention than as a text to show how one can be misunderstood when ignorance and prejudice are used as a lexicon.

I look upon the condition of the bowels in relation to abdominal surgery as local and mechanical, quite as much so as the operation, and one calling for local and mechanical treatment. While habitual constipation is a constitutional state, and requires dynamic treatment, inaction of the intestines, when associated with abdominal operations, is local and mechanical, and must be treated with remedies and measures that act directly upon the organs affected.

At the time of the operation much can be done to prevent and anticipate the complications due to intestinal activity. If the technique is perfect, the intestines should not be seen during the operation, unless they are operated upon; that is to say, they should be pushed out of the field of manipulation, and held there by means of retractors. With experience this is possible in the most complicated operations, and its observance will add materially to success. If it becomes necessary to handle the intestines, or to remove them from the abdomen, the greatest care should be observed not to denude them of their epithelial covering, and to this end I dip my hands in sterilized oil before any extensive manipulation of the intestines. The pads which cover the intestines as they lie outside of the abdomen are also dipped in oil. A retractor wrung out of hot water is liable to adhere to the peritoneal covering of the intestines, and when removed carries some of the epithelial layer with it. A further caution may be added in relation to the retractors used in abdominal operations. It is a common practice to have them as hot as the hand applying them can bear. This I think is a mistake. I am confident that the extreme heat injures the epithelial layer, and has a tendency to cause its desquamation.

Flushing the abdomen as a final step in operations involving manipulation of the intestines is a valuable means against intestinal inactivity. Its beneficial effect is not confined to action upon the bowels, but of these only can we now speak.

I am not an advocate of the routine practice of flushing the peritoneal cavity. Little in surgery is routine, for each case should be treated individually; but when intestinal complications are anticipated flushing should never be omitted from the technique. The presence of the normal salt solution in the abdominal cavity keeps the intestines floating, and assists in restoring them to their proper anatomical relations. Hence I am not particular to remove all the fluid that I have poured in, but allow it to remain in the cavity. It is absorbed quickly, and assists in supplying the system with water, as well as restoring or rather preventing the overcharging of the abdominal and pelvic veins with blood, which constitutes the anæmia of shock.

Another and most important point in the management of the

intestines during an operation is that the abdomen should never be closed while the intestines are distended with gas. This condition may not exist at the beginning of the operation, but if the manipulation is prolonged gas may generate, and the intestines become so distended as to interfere with the closing of the abdomen. Under such circumstances I believe it is wise to open the intestines longitudinally in the coil that presents most prominently. The opening is quickly made and as quickly repaired, and the gut not having lost its peristalsis, expels the gas. Thus the immediate danger of paralysis from distention is averted. I have resorted to this measure in more than one instance; and while I cannot say that success depended upon it, I feel inclined to think that it contributed to success.

And now as to the treatment after the operation. We are confronted with the problem, whether we shall wait for indications of intestinal inactivity, or whether we shall take the initiative and prevent such a possibility. With increasing experience in abdominal surgery, I favor the latter course, and more frequently make it a part of my after-treatment. In my operations I have, so far as nature is concerned, been guilty of a misdemeanor, and done violence to her laws; and I am not possessed of such child-like confidence in nature as to assume that she will submit to any indignity, and repair any loss, or outrage, if we give her an opportunity to do so.

If the operation has been uncomplicated, and attended with a minimum degree of manipulation of the intestines, I do not consider interference necessary for twenty-four hours. But if at the expiration of that time there is no indication of intestinal activity, either by the passage of gas or inclination for stool, I order first an enema to clear out the rectum and colon, followed by calomel and soda, each tablet containing calomel $\frac{1}{10}$ grain and soda 1 grain, this to be followed by some saline, either Epsom salts or Rubinat water. At any rate, I do not rest until I know that the functional activity of the intestinal canal is restored.

My treatment is somewhat different if the operation has been a complicated one, if it has been a pus case, or if I have reason to anticipate sepsis as the result of the operation. I then begin immediately after the operation, as soon as the patient can take anything on the stomach, to administer either citrate of mag-

nesia or Epsom salts in divided doses. Two ounces of the former, and one ounce of the saturated solution of the latter every hour, will be well borne, even by the most delicate stomach. These measures, together with enemata, will usually bring about the desired result unless there is actually developed intestinal obstruction. In cases of sepsis, or suspected sepsis, I sometimes think best to begin the active treatment with mercuriale., or the tablets of calomel and soda, of which I have spoken, which do not disturb the stomach as easily as does the triturated drug. In any case this would be followed by a cathartic. Of course, if vomiting forms a feature of the case, the rectum will be utilized for the purpose of medication. But this is rarely necessary. I have been surprised to note how tolerant the stomach is of the very cathartic which at another time it would reject.

If the measures to re-establish the functional activity of the intestines which I have indicated as the ones that I favor (and in this I desire to disclaim any originality, even though I may not have been aware of priority of usage) fail, we must not abandon the case, nor can we delay too long the radical treatment of an operation for relief. Intestinal obstruction is not always associated with peritonitis, either as a cause or an effect, but when it exists, unless promptly relieved, it means death. No medical treatment thus far proposed can be relied upon with confidence. The intestine inactive, either from paralysis, which leads to actual obstruction, or mechanical closure of its calibre, has lost its power of contraction, and cannot be acted upon dynamically, but calls for mechanical aid. Therefore, let us give these desperate cases the benefit of a desperate operation. Without it they are sure to die; with it, they have a chance of life.

In making the operation for acute intestinal obstruction, we have mainly two points to consider. First, and foremost, the life of the patient. This may seem a trite remark, but I believe the surgeon sometimes has more regard for the operation, as such, than for the life of the patient. In other words, the cosmetic effect is uppermost in his surgical mind. He finishes the operation according to his ideal, and makes it a complete procedure, not considering that the less cosmetic effect may save the patient's life. Let us apply this to the present ques-

tion. The patient who comes to the operation for the relief of acute intestinal obstruction, has almost everything against her, almost nothing in her favor. The system is profoundly shocked, if not poisoned, and every hour, even every minute, will tell for or against the final issue. Therefore, time is a most important element in the treatment, and that treatment is the most successful that consumes the least time. With the intestines distended with gas, it is frequently an exceedingly difficult matter to find the seat of obstruction, and if the inaction is caused by paralysis, there is no one point where the obstruction is located. Again, prolonged search necessitates the use of general anæsthesia, which must be deprecated in the condition under which the operation is performed. It also necessitates additional manipulation of the abdominal contents and organs. Hence it seems wiser, I will almost say in the majority of cases of acute intestinal obstruction following laparotomy, to divide the operation into two parts. In the primary operation, if the seat of obstruction does not at once become evident, to spend no unnecessary time in seeking for it, but to open the intestine without delay, at the coil that presents itself, and quickly make an artificial anus. The second operation may be undertaken at a more or less remote period, and has for its object the closing of the opening of the gut. The first operation is so simple that it can be done with local anæsthesia, an inestimable advantage. The second operation can be done with ease and success, if the first opening and method of securing the gut to the abdominal wall has been done with that end in view.

IS OUR MATERIA MEDICA BECOMING ONE OF THE "LOST ARTS?"

BY W. J. MARTIN, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society, State of Penna., Wilkesbarre, Sept. 26, 1900.)

IN this paper I will narrate some of the circumstances and incidents that have led me to present the query which is the paper's title, and leave you draw your own conclusions. At our hospital we get a fresh set of internes every year. They are generally bright young fellows, fresh from the "Halls of

Galen," earnest and enthusiastic in the determination to go out into the world well equipped with the knowledge, and some of the practical experience, that go to make a successful physician. But there is one thing that I have noticed about these young graduates, and I notice it more and more each succeeding year, and that is that, as a rule, they know less about homœopathic materia medica and therapeutics than they do about anything else pertaining to the general practice of medicine. A recent incident in illustration. One day last winter I visited the hospital, having been absent for several days. The junior resident accompanied me on my rounds. In a private room was a man with typhoid fever. He had been sick about two weeks. There had been nothing peculiar about the case except that it seemed like one that was going to drag along a good while. He was taking rhus, and for a week or more the evening temperature stood between 103° and 104°. He was a red-faced man, and was not very refined in his ways. The resident handed me the records, and we looked over the history of the case as recorded by the nurse. The last two days the nurse had made record of the fact that this patient was annoyed by burning of the soles of the feet; she had much trouble in keeping them covered, as he persisted in putting them out from under the covers, and she feared he would take cold, and he declared that he could not tolerate the burning when under the covers. She would cover the feet, expostulate, possibly scold, and leave him to attend to other patients, and on returning he would have his feet uncovered. She very properly made prominent mention of this feature each day, never dreaming what a good service she was thereby doing.

"Now," to the junior resident I said, "'burning of the soles of the feet, wants them uncovered,' is a very prominent symptom of a remedy; will you name the remedy?" To my astonishment he said he did not know it; had never heard of it. I told him it was time he did know; that when I was at college we all knew that symptom long enough before we graduated; many of us before we went to college. It is sulphur. Write a prescription for one dose of sulphur 200 every morning for three mornings, and then no more medicine until it was ordered. When the patient had taken the third dose he had no need for any medicine. Everything was normal, and in

a few weeks he went out of the hospital well and quite strong.

The junior resident, in extenuation of his ignorance, claimed that Prof. M. had not lectured on sulphur. I thought that in all probability Prof. M. had given so much of sulphur by way of comparisons in lectures on other drugs that it was not thought necessary to take time for a special lecture on that remedy.

Another incident. When I took charge last winter there had been several days elapsed since the last visit of my predecessor. In this interval several cases of acute muscular rheumatism were taken in, and were prescribed for by the resident on the medical side. I noticed that he was giving them all the same thing—and no two of the cases were alike, by any means—he was giving them all colchicine in some kind of a dilution. I asked him what symptoms called for the administration of this remedy, as I was not familiar with it. He told me it was indicated in all cases of acute rheumatism where there was high fever and the patient suffered very much pain. "Where did you learn that?" "That is taught at college." "Well, that is not the way patients are treated here while I am on duty." I then explained to him the way to prescribe for patients, as I had learned it at college under the tuition of a certain Prof. Korndørfer some twenty-three years ago, and which had since always served me well.

The day before this the same interne had an interview with me over the telephone. He told me a case had just been brought in which was evidently a bad case of cerebral apoplexy—unconscious, stertorous breathing, contracted pupils, etc. "Would he pack his head in ice?" "No; administer the indicated remedy and leave his head alone," was my answer. I thought that it would take this young man some time to unlearn some of the things he had learned at college. Nash's "Leaders in Typhoid" came out about this time. I presented the young doctor with a copy, and when I went off duty he was doing some very good prescribing.

I was at a meeting of a medical club not long since—I very rarely go to our medical society meetings any more, because there is little or no homœopathy in them—but this club does serve some elegant lunches which I enjoy very much. On this

occasion the treatment of post-partum hæmorrhage was being discussed. One of the young members—a graduate of one of our best, so considered, homœopathic colleges—remarked that he would be afraid to trust to homœopathic remedies in such a serious condition as post-partum hæmorrhage. What do you think of this? A declaration such as this to be made in a Homœopathic Medical Club; and it passed unchallenged. I was an invited guest. I did not say anything, but I thought it would be interesting to know in what kind of conditions this young man did trust to homœopathic remedies.

At another meeting of this same club a young member—a particularly bright young man, so considered—occupied a large share of the evening in describing in minutest detail the process of treating gonorrhœa by the copious injection of a 5 per cent. solution of permanganate of potash into the bladder. The bladder being filled with the solution, the patient is then to evacuate it. He told of his success in a number of cases recently so treated. Another member said he was having success with the bromide of camphor in priapism and chordee accompanying gonorrhœa. “The old school,” he said, “are using it very extensively.” I was a guest. I said nothing, but I thought were it possible for Hahnemann himself or some of the “Old Guard” to come in spirit to this meeting they would not for a moment suspect that it was a meeting of a Homœopathic Medical Club.

Commenting upon the recent meeting of the American Institute of Homœopathy, the Philadelphia *Medical Journal* (old school) says, July 7, 1900, in part, as follows: “In the City of Washington, on June 21st, the American Institute of Homœopathy unveiled with fitting ceremonies a monument of Samuel Hahnemann. President McKinley occupied the most prominent seat upon the platform, where sat also H. B. F. McFarland, Commissioner of the District of Columbia, General John M. Wilson, and Mr. Cortelyou, Secretary to the President. Attorney General Griggs delivered a short and spirited oration. The monument, very beautiful from an artistic standpoint, occupies one of the choicest positions in the city, facing the statues of General Winfield Scott and Daniel Webster.

“‘Specialism,’ into which field the homœopaths have freely

entered, occupied the greater part of the purely medical side of the week's transactions. The papers read did not differ materially in their points of view from papers upon similar subjects read before other medical bodies. Owing to the time occupied in thanking the Monument Committee and the President of the United States, etc., exactly but two hours were spent in reading and discussing papers at the meeting of the Section of Materia Medica. The treatment of diseases allopathically was stated by Dr. E. C. Price, of Baltimore, to be right and proper under certain circumstances, *i.e.*, upon the failure of homœopathic remedies; for Hahnemann says 'the first duty of a physician is to relieve the sick.' Doubts and disagreements with the principles of Hahnemann are, to use the words of a disciple present, 'creeping into the journals, hospitals and colleges of the homœopaths.'

"Indeed, the tendency of the whole meeting went to show that the term 'homœopath' is but a trade designation, and does not include adherence to the principle implied. And yet the homœopaths have raised in the Capital of the United States a monument resembling an altar, upon the base of which is inscribed the words '*Similia Similibus Curantur.*'"

I was one of the many who did not attend the meeting of the Section on Materia Medica; consequently do not know personally if Dr. Price, of Baltimore, said Hahnemann says "the first duty of a physician is to relieve the sick." I do know, though, that Hahnemann never said any such thing. What Hahneman did say was, "The physician's highest and only calling is to restore health to the sick, which is called healing." Relieving the sick is not restoring health to the sick—not always, I am sure. If, as reported, Dr. Price said "it was right and proper to use allopathic remedies when homœopathic remedies failed," he was very unfortunate in using this expression—an expression that never should be made use of—for homœopathic remedies do not fail; the failures are due to the fact that the remedies used were not the homœopathic ones. The rest of the report that I have quoted is substantially true and correct. It is true and correct that the papers read in the various sections were in the line of specialties, and did not differ materially from papers on similar subjects read before other medical bodies; and if it is not true, it is pretty nearly

true that the tendency of the whole meeting went to show that the term Homœopath is but a trade designation, and does not include adherence to the principle implied.

A great deal was said at this meeting, a great deal has been said at other meetings, a great deal has been published in some medical journals of our school concerning the definition of the term Homœopathic Physician.

On the title-page of the last volume of the Transactions of the American Institute of Homœopathy appears conspicuously, under the headings "Authorized Definition" and "Definition of a Homœopathic Physician," a lot of silly stuff about "great field of medical learning," "by tradition," "by inheritance," etc. It makes one tired to read it.

The greatest man this country ever produced was Abraham Lincoln, "the martyr President." This I believe is conceded by all unprejudiced students of American history. He possessed the faculty to a degree that no man ever before did, and probably no man ever again will, of expressing great ideas in the simple language of the plain people. It was he who said: "You can fool all the people sometimes; you can fool some people all the time; but you cannot fool all the people all the time." Those persons who have been cudgeling their brains and juggling with words in the vain work of framing specious definitions of a Homœopathic Physician may succeed thereby in fooling some people all the time, and of fooling all the people for some time, but it is as sure as fate they will fail to fool all the people all the time. This definition-making episode has revealed a remarkable mental condition on the part of those who are working up these various specious definitions. It has revealed the sublimely ridiculous spectacle of a set of men—educated men, too,—trying to fool themselves, trying to make themselves believe, by some kind of play upon words, that a physician who does not practice homœopathy is, or may be, a Homœopathic Physician. They all know as well as we know, and as every one knows, that instead of its requiring thirty-five words to define Homœopathic Physician (which is the number of words in the authorized definition, some of the unauthorized definitions have a great many more), eight words only are required, viz.: A Homœopathic Physician is one who practices homœopathy. This is what a Homœopathic Physician is; this, and nothing more; but all of this.

Fondly do we hope, sincerely do we pray, that future editions of the Transactions of the American Institute of Homœopathy will not continue to make us the laughing-stock of the whole country by the continued publication, conspicuously, of those "Authorized Definitions."

COMPOUND DISLOCATION OF THE KNEE.

BY GUSTAVE A. VAN LENNEP, M.D., PHILADELPHIA, PA.

(Read before the Surgical and Gynecological Association of the American Institute of Homœopathy.)

ON the evening of September 22, 1899, S. A. G., aged 10 years, while riding a bicycle, attempted to cross the street in front of a moving trolley car. The fender of the car struck the wheel, throwing the boy off, and dragging him along the ground between it and the track. The left leg was caught and the knee hyperextended to such an extent that the toes touched his shoulder.

He was seen about an hour after the accident, in consultation with Dr. O. B. Wait. On examination there was found a wound in the popliteal space, to the outer side, about two inches long, through which the head of the *tibia* had protruded, but had been replaced by Dr. Wait, who had dressed the wound antiseptically immediately after the injury. At first sight the knee appeared normal, but Dr. Wait assured me that there had been a backward dislocation, which he had reduced, and that the head of the *tibia* had forced its way through the skin in the popliteal space. There was perfect flexion and extension, though of course attended with severe pain.

Ether was administered and a more careful examination made. The fingers introduced into the wound easily passed into the cavity of the joint through the widely-torn ligamentum posticum of Winslow. The crucial ligaments were entirely detached, as well as the internal lateral ligaments. The articular cartilages were not injured, and particular care was taken to ascertain the position and state of the semi-lunar cartilages. By grasping the leg and moving it, lateral mobility could be easily obtained; the *tibia* could also be depressed, so that the

anterior edge of the articular surface came in contact with the posterior edge of the condyles of the femur. In other words, the dislocation could easily be reproduced and reduced. The same displacement took place through muscular action while the patient was in the stage of excitement during the administration of the anæsthetic. This fact satisfied me that the muscular attachments to the tibia, posteriorly, were intact; the muscles that bound the popliteal space were simply pushed aside and the head of the tibia allowed to protrude through the soft structures.

The skin over the patella and the front of the leg down to the ankle was extensively bruised and denuded; several large sloughs formed and had to be removed. The wounds were dressed at first with mild antiseptic solutions, and later, after separation was complete, cicatrization was materially hastened by the application of aristol, both in the powder form and also as an ointment in combination with petrolatum.

It seemed almost like a miracle that with such laceration of the popliteal space, and consequent stretching of the vessels coincident to the position of the limb, they should have escaped injury. They probably were, along with the nerve, stretched across the posterior sharp edge of the head of the tibia, compressed for the time, but resuming their natural condition when the pressure was removed. Or they may have slipped to one side, as the wound through which the tibia protruded was well to the outer side, and close to the tendon of the biceps femoris muscle. The opening on the skin was small, but the soft tissues underneath were torn and separated extensively. There was no hæmorrhage, either at the time of the accident or following it.

The wound was enlarged, giving free drainage; the joint was washed out, cleansed of blood-clots and *débris*, and the wound packed with iodoform gauze. A strong posterior splint of plaster of Paris was applied, with the leg slightly flexed, so as to have it in the most useful position if ankylosis resulted, there being every reason to believe that such would be the case.

After the initial "aseptic fever," the temperature and pulse ran a normal course, the wound healed by granulation, and was entirely closed by the end of two months. The limb was kept

in the splint continuously, in order to overcome the marked tendency to contraction of the flexor muscles. Passive motion was instituted the third week, moving the joint through the normal arc, stopping short of acute pain. When the wound healed, a plaster-of-Paris cast was put on, and the patient allowed to walk. This has been worn continuously since, on account of a certain persistence of the lateral mobility, and a tendency to genu valgum, due, no doubt, to the torn and weak internal lateral ligament. It is removed at night, and also for massage, and to allow the patient to exercise the knee.

The result is all that could be desired; there is flexion to well beyond a right angle, and extension to almost the straight position. The knee shows weakness, however, in that the lateral mobility and the knock knee still persist, and call for constant support. The photographs show the present condition much better than it can be described, also the amount of flexion possible, and the scars in the popliteal space, close to the outer hamstring tendon.

Dislocation of the knee, or, better, dislocation of the tibia, is fortunately a rare injury, constituting about 1 per cent. of all dislocations. In 812 dislocations of all kinds seen at St. Thomas' hospital,* one was of the tibia, or only 0.123 per cent. In another table of 400 cases, 4 were of the tibia, or 1 per cent. Not one of the five was complete.

The forward variety is by far the most common, and is the most liable to be compound. Of 114 cases of traumatic dislocation collected by Stimson,† it was forward in 52, backward in 34, outward in 21, inward in 4, "lateral" in 1, and by rotation in 3. Of this number 21 were compound, 11 forward, 4 backward, 6 outward. The wound in the forward and backward forms is usually found in the popliteal space, the soft parts rupturing where they are stretched across the projecting condyles of the femur, or the head of the tibia. The cause of dislocation of the knee is found in either hyperextension, as in this case, which produces either a backward or a forward dislocation, or external violence received on the back part of the leg or the front of the thigh near the knee, which causes a forward

* Warren Gould, "International Text-book of Surgery," vol. i., p. 637.

† Stimson, "Frac. and Disloc.," p. 752.

displacement, the reverse being responsible for the backward variety. Lateral luxations are more frequently caused by abduction or adduction of the leg, are much rarer than the preceding forms, and very seldom complete.

The posterior, lateral and crucial ligaments are first put upon the stretch, then rupture, allowing the tibia to slip forward or backward along the condyles until it assumes a position completely or partially anterior or posterior to the latter. In the incomplete form the injuries to the ligaments and soft structures are slight, and as a rule a good result as to function can be expected. In the complete variety, the injuries are much more extensive. The posterior or both lateral and the crucial ligaments are torn, as well as the soft structures immediately around the joint; and even the posterior muscles, the biceps, gastrocnemius, popliteus, soleus and vastus internus may be ruptured. The condyles may be felt lying immediately underneath the skin, or they may protrude. Overriding of the tibia and femur in the forward form varies from one to four inches. Shortening is present only in the complete variety, and then amounts to one or two inches.

The patella is usually displaced, the ligamentum patellæ put upon the stretch, and the lateral ligaments may be torn.

In a case reported by Fitzgerald,* the patella was comminuted, and finally sloughed through. The joint suppurated, but the man finally recovered with a useful limb. In another† the ligamentum patellæ was torn away from its attachment to the tubercle of the tibia, bringing away a portion of the bone with it.

Injury to the popliteal vessels and nerve is of special importance. The artery has been completely torn across, or there has occurred rupture of the inner and middle coats, with consequent blocking of the lumen of the vessel and the formation of a thrombus. One such case is reported by Annandale.‡ The patient sustained a forward dislocation by falling from a ladder. It was easily reduced, and the patient did well for a week, with the exception of a feeling of coldness of the foot. Sensation was normal. At the end of that time gangrene set in, and

* Fitzgerald, *Australian Medical Journal*, 1882, p. 554.

† Vast, *Bull. de la Soc. de Chirurgie*, 1877, p. 688.

‡ Annandale, *Lancet*, 1881, vol. ii., p. 903.

amputation was done above the knee. The popliteal artery was normal in its upper portion. The lower part was plugged by a thrombus. On cutting the vessel open the middle and inner coats were found torn and their edges curled inward. The vessel was atheromatous. The popliteal vein was normal. In a case examined by Malgaigne,* numerous small rents were found in the vessel, taking place at calcareous points. In Vevers'† case of simple forward dislocation the symptoms were similar, there being coldness of the foot, which was swollen and painful. Ten days after the accident the limb was amputated above the knee for dry gangrene. The popliteal artery was found ruptured opposite the flexure of the knee, the torn ends were retracted and plugged with clots. There was little extravasation of blood, and the vein was intact though dilated and filled with dark blood. The nerve was stained and flattened out, as if from pressure where it came in contact with the swollen vein. The posterior, both lateral and both crucial ligaments, were torn.

It is of interest to note that in most of the cases reported it has been the artery that has sustained the severest injury. The vein, in the majority of cases, appears to have escaped rupture, although it may, of course, be bruised, in which case it becomes the seat of a thrombus. Injury to the nerve is of less frequent occurrence and of less import than injury to the vessels. It is manifested by loss of sensation and numbness; later by pain and changes depending on defective nutrition of the limb. In a case reported by Le Dentu‡ of complete dislocation of both knees, the man suffered intense pain in the legs, of a neuralgic order, followed by the appearance of eschars on the calf, the heel, and the sole of the foot, the first making its appearance nineteen days after the accident, the last on the forty-fifth day. The patient ultimately recovered, with good motion in the knees, but with considerable atrophy of the right leg and loss of power in the muscles. The trophic troubles were attributed to a neuritis of the popliteal nerves.

In the treatment of compound dislocations conservatism is to be strongly recommended. If the vessels are torn or

* Quoted by Stimson, "Frac. and Disloc.," p. 752.

† Vevers, *Lancet*, 1869, vol. ii., p. 542.

‡ LeDentu, *Bull. de la Soc. de Chirurgie*, 1880, p. 591.

bruised to such an extent that a thrombus forms, amputation will be necessary, though in these cases it is better to wait until the resulting gangrene is developed than to take off the limb at once. Dry gangrene is accompanied by slight constitutional disturbances, and a definite line of demarcation can be awaited. In the moist variety it is better to amputate as soon as the process appears. In the absence of complications, such as injury to the vessels or nerve, a good result should be obtained, even if the dislocation should be compound. It is remarkable how much damage a knee joint can withstand and yet heal with good motion. In Percival's* case there was a compound dislocation of the knee inwards, with the leg at right angles to the thigh. The man had also a compound dislocation of the ankle of the same leg; yet he recovered with a useful knee, flexion to a right angle, patella freely movable, and no grating.

It should be remembered, however, that if suppuration intervenes, complete ankylosis may result, so it is safer in all cases to keep the joint in the best position for a stiff limb, *i.e.*, just short of complete extension. A joint with very little or even no motion is much more useful than an artificial limb.

Reduction of the dislocation is usually easily accomplished by traction and manipulation, assisted by flexion of the leg, although in Spence's† case of backward dislocation the manipulative, continuous extension with weights, and the pulley methods, were successively tried and failed. The joint was then opened by making a semi-lunar incision below the patella, as in excision of the knee, and the tibia replaced only after dividing the external lateral ligaments and the tendons of the hamstring muscles.

In the case presented, reduction was easily accomplished by using slight traction, at the same time flexing the limb and lifting the head of the tibia forward, with the hand placed on the back part of the leg just below the popliteal space.

* Percival, *British Med. Journ.*, London, 1888, vol. i., p. 1383.

† Spence, *Lancet*, 1876, vol. ii., p. 534.

MAGNESIUM SULPHATE IN SUMMER DIARRHŒAS OF CHILDREN.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

SEVERAL years ago there went the rounds of the literature a few articles on the use of magnesium salts in dysentery. I read them, and paid but little attention to them then. But this summer I have been having some trouble with the various kinds of summer diarrhœas of children, and particularly with entero-colitis. *Mercurius dulcis* 2x, as recommended by Professor Goodno in his work, would act well whenever indicated by the greenish stools, but somehow this kind of patient has not been met with during the late summer and beginning of fall. The diarrhœa would begin as a "dyspeptic" diarrhœa, or one due to toxic fermentation. There would be vomiting of food and bile, and passage of copious yellowish, slimy and stinking stools, which later would become merely watery serum. This would, if unchecked, pass into an entero-colitis, with frequent slimy and blood-tinged stools. Here calomel is a favorite remedy in the second decimal trituration, repeated every one or two hours. I must say that I never have had much success with calomel unless the stools were greenish. At any rate, this latter drug did not seem to relieve these diarrhœas of an entero-colitic tendency, and in casting about for another I fell to thinking of magnesium sulphate. In speaking of it with various physicians, and particularly those of the old school, I found that some of them were in the habit of employing it in a saturated solution in dysenteric cases. I then commenced with a weaker one of about a half to one grain to the teaspoonful, and found that it acted well. I noted that as soon as it had begun to bring a favorable influence to bear the stools would become bile-tinged, which was always a sign of commencing improvement; then, in the course of a day or so, the stool would become more and more mixed with bile, and thicker, until recovery would sooner or later follow. The capital point would be the copiousness of the stools, which seemed to point to a desire of nature to flush out the intestinal tract of some

irritating toxic substance. Naturally, if this were continued for some time, the child would rapidly fail in strength and lose flesh.

Andrew Davidson* speaks of magnesium sulphate being employed with success in Bengal for dysentery. At another place it is stated that the saline treatment is very popular in these bowel troubles in France.

Every one knows who has taken a dose of "salts" what a copious stool of a watery consistency it will produce. Therefore, though the homœopathic provings of our drug are scanty, it has to me been of some value in these cases described.

There is a point in feeding to which it might be well to refer. Some German writer, Escherich, I believe, divides the stools of summer diarrhœa into acid and alkaline. In acid ones albuminoids agree, that is, albumin water and such foods; while if the discharges be alkaline these foods will not be tolerated. Then barley water I have found of the most service. Later, after a few days, a little milk may be added, the quantity of which may be gradually increased as the patient improves.

TUBERCULOSIS—HOW BEST TO PREVENT IT.

BY WILLIAM H. VAN DEN BURG, M.D., NEW YORK,

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(Read before the Semi-Annual Meeting of the Homœopathic Medical Society of the
State of New York, October 4, 1900.)

Mr. President and Members of the Society: In the few words I shall have to say on the subject of tuberculosis I shall not hope to present anything new, but simply to reiterate and emphasize facts which have been repeatedly stated by eminent authorities upon this disease. Neither is it my purpose to enter into minute particulars, but to call your attention in a general way to what seems to me the chief features of this most important subject. To best understand the methods of preventing any malady, we must first have a complete knowledge of what the disease consists, and this we possess in the

* *Albutt's System of Medicine*, vol. ii., p. 435.

subject under consideration probably in as great a degree as in any disease we are called upon to treat.

Since the discovery and the description of the life-history of the bacillus tuberculosis by Koch in 1882, all authorities agree that tuberculosis is an infective disease, caused by the invasion of the system by the bacillus tuberculosis. This fact has not been doubted in the scientific world since the publication of Koch's treatises of that year. These form one of the most masterly demonstrations recorded in the history of modern medicine. This is attested by the fact that in the years which have elapsed since their appearance the innumerable workers on the subject have added scarcely a single essential fact to those presented by Koch at that early date. While no essential facts have been added to our knowledge since 1882, real, genuine progress of value to humanity has, nevertheless, been accomplished by the gradual diffusion and acceptance of the doctrine that every case of phthisis is the result of a specific infection.

When this truth has sufficiently penetrated the popular mind to cause the utilization of the necessary preventive measures, tuberculosis will be as rare in this country as cholera and small-pox are to-day. In Massachusetts, owing to a more general acceptance of this ætiological factor, the death-rate has already fallen from 42 per 10,000 inhabitants in 1853 to 21.8 per 10,000 in 1895. In the "Sanitary History of Glasgow" James R. Russell says: "Between the five years 1870 to 1874, and the five years 1890 to 1894, there was a decrease of 41 per cent. in the death-rate." There has also been a corresponding reduction in all large centres of population where the specific cause of the disease has been recognized. Notwithstanding these material reductions in certain localities, the total death-rate for the United States is not greatly diminished, because of the non-recognition, in parts remote from scientific centres, of the fact that tuberculosis in all its forms is caused by the entrance into the system and its multiplication there of the bacillus tuberculosis.

Tuberculosis is not an hereditary disease as such. Nobody is foredoomed to die of any of the forms of phthisis, provided that this bacillus is kept from entering his system. Keeping these facts in mind, the methods for preventing this disease outline themselves as follows:

- 1st. The thorough education of the general public.
- 2d. The early diagnosis of existing disease by the physician.
- 3d. Complete destruction of all tuberculous material and excretions.

4th. Proper hygienic surroundings for the non-infected.

5th. The treatment of the infected in special hospitals.

Physicians must be the educators of the public on this subject. It should be the duty of every physician to instruct all his patients that tuberculous infection usually takes place by inhalation of dust containing dried tubercle bacilli, by the use of milk from infected animals, and by the use of tuberculous meat. The laity, when thoroughly aroused to their danger from these sources, will readily co-operate with physicians in preventing the spread of infection from any particular case, and will demand thorough and competent inspection of their meat and milk supply. It is my firm belief, if these simple precautions could be made effective, as they surely can be when the public is brought to realize the necessity for them, that in a few years tuberculosis could be practically eliminated.

As a preventive measure, the importance of an early diagnosis of tuberculous lesions cannot be too greatly emphasized. The habit of procrastinating, and telling patients with a cough that they have weak lungs or some throat trouble, is a pernicious practice, and too often makes a new focus for disseminating the tubercle bacillus. In all throat and lung troubles the true nature of the disease should be ascertained even before there is much expectoration, and, if tuberculosis, the patient informed of the serious nature of his malady, and specific instruction given to prevent his becoming a menace to society. In every community, at present, there are one or more physicians skilled in modern methods of diagnosis, to whom all early doubtful cases should be referred for examination. This would prevent waiting for time to dispel the doubt, and meanwhile allowing enough tuberculous material to become mixed with the dust to infect an entire community, as has been too often the practice.

To prevent infection by inhalation, all persons suffering from tuberculosis, and all nurses and attendants, as well as the various members of the family, must be impressed by the physician with the necessity for the thorough destruction of

all discharges, such as sputum, etc., before it becomes dried, and thus disseminated in the dust of the apartment or street, to be inhaled by others. The patient and the family must be thoroughly alarmed as to the possible danger to themselves by a neglect of these precautions. Sputum should never be discharged into handkerchiefs nor expectorated upon the streets, and the utmost care must be exercised to prevent its coming into contact with the bed-linen or clothing, where it is liable to dry and become a source of infection. In the case of male patients, where small particles of sputum are likely to adhere to the beard, the greatest care must be exercised. These few regulations, so universally neglected, if as systematically observed as they now would be in a case of small-pox would go far toward eliminating this scourge.

Much can be done to destroy existing infectious material and to prevent its multiplication by the introduction of sunlight into dwellings and living-rooms, by the abolishing of dark spaces and enclosures, by the removal of dampness, by sub-soil drainage, and by the thorough ventilation of all habitations. Direct sunlight is the greatest foe to all infectious material, and this applies in no less degree to tuberculosis. The tubercle bacillus thrives best in dark and dirty places. This is illustrated by the experiments of Trudeau, who found that rabbits inoculated with tuberculosis, if confined in a damp, dark place, without sunlight and fresh air, rapidly succumbed, while others treated in the same way, but allowed to run wild, either recovered or showed slight lesions. Also, statistics gathered some time since by Weichselbaum, of Vienna, showed a death-rate of 25 to 75 for 10,000 living between the ages of 15 and 60 for residents of cities; while the death-rate was 120 to 175 per 10,000 living at the same age among residents of convents, where the quarters were more cramped and sunlight less generally present.

Tuberculosis should not be treated in general hospitals. It is almost impossible to prevent hospital wards from becoming infected if tuberculous cases are admitted. *Apropos* of this, the experiments conducted by Strauss at the Charité Hospital in Paris are important. In order to collect the dust of the wards he placed plugs of cotton wool in the nostrils of twenty-nine nurses, assistants and ward-tenders. In nine of the twenty-

nine cases these plugs contained tubercle bacilli which proved infective to animals. In Flick's study of this subject in a single city ward in Philadelphia, his researches go far to show that it is a house disease. Less than one-third of the houses of the ward became infected with tuberculosis prior to 1888, yet more than one-half of the deaths from tuberculosis during the year 1888 occurred in those infected houses. These two investigations will show the importance of isolation in special hospitals if our efforts for prevention are to be most effective. As we cannot hope to acquire enough hospitals to accommodate all cases for some years to come, the preventive measures before mentioned assume a greater importance.

In closing, I wish to repeat that, in the prevention of tuberculosis, the thorough enlightenment of the public is the most important element.

EMBRYONIC UMBILICAL HERNIA.

BY E. M. HOWARD, M.D., CAMDEN, N. J.

WITH complete eventration of abdominal viscera the accompanying photograph shows a recent instance of this comparatively rare deformity. This child was born at full time and lived twelve days. The photograph shows the relative size of the tumor nicely. The appearance of the sac at the time of birth was that of the umbilical cord, which was attached at its summit, and of which it seemed to be a dilatation. The delicate outer covering soon became necrotic, and the child, which was otherwise healthy, though weak, died ultimately from septicæmia. It nursed well, and its bowel movements were normal.

A post-mortem was obtained, and the sac was discovered to contain the entire liver, spleen, pancreas, stomach, all the small and most of the large intestines, and all the abdominal viscera except the kidneys, which were normally placed.

Careful inquiry was made as to any possible cause. It was the firstborn of young people, who had been married about one year. Both parents are healthy and have good family records. There is no history of fright or sudden emotion beyond the extraction of a tooth by the aid of gas during the

first two months. About the end of the second month the husband, during coition, was supporting his weight with his hands, when they suddenly slipped and he fell upon her abdomen so heavily as to give her great abdominal pain at the time, and leaving a soreness that lasted for some days. This would seem to me to have been the likely cause.

The only report of a similar case I have seen was made in October last by Dr. T. H. Manley, of New York. He reported the sac in his case to contain the same viscera as mine. He attempted operation, but found it impossible to do anything, and his child died in a few hours. I did not attempt any operation, seeing no chance whatever.



I was told by one of the physicians present at the post-mortem that there had been cases reported in which the kidneys were also eventrated.

A deformity of this character constitutes a congenital monstrosity, and is not to be compared, as Dr. Manley does, with those more common minor varieties of embryonic hernia where there is some chance of relief by operation.

THE INDUCTION OF ABORTION WITH IODINE.—Oehlschlager has employed the following method for a series of years without any untoward incidents. It is especially applicable to early pregnancy. He inserts a curved metal catheter, having a lumen of 2 mm., up to the fundus uteri, and injects 3 or 4 grammes of tincture of iodine. An ordinary tampon is put in the vagina to protect it from the iodine after the instrument is withdrawn. Abortion takes place on the third day, with the usual symptoms of menstruation. It at once destroys foetal life. It is an antiseptic, and penetrates the tissues without producing an injurious effect. It excites uterine contractions by local irritation.—*Centralblatt für Gynakologie*, No. 27, 1900.

HOMŒOPATHY TO-DAY—HAVE WE PROGRESSED OR RETROGRADED?

BY F. PARK LEWIS, M.D., BUFFALO, N. Y.

(Read before the Homœopathic Medical Society, State of New York, October 4, 1900.)

At no period of the world's history have definite scientific advances in medicine been so numerous, so exact and helpful, as during the past quarter of a century, and the fundamental basis upon which this progress was established has been the careful and intelligent study of the causes of disease. This has been the underlying stratum upon which the whole superstructure of the germ-doctrine has been established. This alone has revolutionized surgery; has given us new light on epidemiology; has shown us how to limit, or even eliminate, infections; has made diagnosis more accurate, and modified all methods of treatment.

The study of causes has made us investigate anew the chemistry of living bodies, has taught us the reactions of the vital fluids, and has given us a truer understanding of a whole group of diseases, functional and organic, febricular and nervous, which we have learned are auto-toxæmias, and which are superinduced by unsanitary living or by abnormal hygiene.

The study of causes has given another class of diseases into our helpful control, the reflexes, and now it is a matter of daily experience for us to find a chorea dependent upon an eye-strain and cured by its correction, convulsions excited by an adherent prepuce and relieved by its loosening, and a train of nervous phenomena dissipated by the removal of an irritable ovary.

But remarkable as has been the progress of general medicine, it will be found on careful analysis that it has been almost wholly within what are termed rational lines, *i.e.*, the recognition of the nature and causes of disease, general sanitation, physiology, diagnosis and preventive medicine.

In pure therapeutics there are only two general lines of inquiry that appear to have more than an ephemeral value. And indeed these are not, strictly speaking, matters of drug-giving

at all, for local anæsthesia, which has given us the marvellous drug cocaine, belongs almost exclusively to the domain of surgery, its medicinal effect being wofully on the wrong side of the ledger account. There remains, then, only serum therapy, with the distinctly new fact that an immunizing protection can be given, at least within restricted lines, against disease; and, unless the toxic involvement has been too profound, its curative influence when disease has acutely developed.

And glandular therapy, vital and important as it is, is not a therapeutic measure in the true sense of the term, but a method by which the system has restored to it an essential element which, through the disease or absence of the producing organ, is deficient in quantity, or does not secrete at all.

A possible third measure is photo-therapy, which, while interesting and suggestive, is entirely outside the domain of drug-giving, and is too new to have a scientific value.

General medicine, therefore, after twenty-five of the most important and productive years of the century, has not one distinctively new and permanent therapeutic addition to present to the world.

Has the great wing of the medical profession devoted to the promulgation of a therapeutic dogma done better?

Let us in this jubilee year look fairly and dispassionately at our share of the work. Twenty-five years have augmented our numbers until to-day there are probably twice as many homœopathic practitioners in the United States as there were in 1875. New colleges have sprung up, old colleges have become bigger, and finer, and richer. Better than that, the educational standard has been raised, curricula have been broadened; special departments have been introduced, until it can at least be said that the average homœopathic graduate is as well qualified as is his old-school colleague.

But now we hesitate. Post-graduate opportunities which have become imperative for the progressive student have been exceedingly meagre within homœopathic lines. The young doctor, if he be ambitious and have a conscientious desire to fully equip himself for the responsible work to which he has consecrated his life, must go where liberal endowments have given great clinical advantages, and in the amphitheatres of the hospitals in this country and abroad will be found a multitude of homœopathic practitioners.

Our surgeons to-day stand with the foremost, and there is no specialty which is not represented by men thoroughly trained for the work; but while we have participated in this great forward movement, we have not led in it. I do not recall to-day one new procedure which the world has accepted that has come from a homœopathic source.

We have no men engaged in what the Germans call "Arbeits," in which reliable data are gathered that trustworthy deductions may be drawn from them. We are studying and making application of the work of investigators, but in the broad field of general medicine we are, as a body, adding nothing to the *summum bonum* of useful knowledge. Because, doubtless, we have been so profoundly occupied in the elaboration of those great fundamental principles which gave us a right to a separate existence? Let us see. I do not now recall a single distinctly *homœopathic* fact that has been added to our therapeutic armamentarium during the past twenty-five years. Not that we have been without conscientious workers. True, we have had encyclopædias and cyclopædias, guiding symptoms and handbooks, and volumes on special therapeutics galore, but we have merely dug up and turned over the rich inheritance come down to us from our fathers and our fathers' fathers. It is now more than a century since the world's greatest medical philosopher promulgated a definite and specific law of cure. He almost alone investigated, with German patience and accuracy, the action of drugs upon the human system. And the wealth of the storehouse which he so richly filled has been the treasury from which succeeding generations have drawn their supplies. But a hundred years have so changed and modified the conditions under which disease is studied that the old truths, to be valid and vital, must be written in the terms and language of the science of to-day.

Provings made before the days of the microscope and the ophthalmoscope and the phonendoscope are full of absurdities to the student of modern pathology. Yet these incongruities are issued hot from the press in the year of our Lord 1900.

The lack of scientific accuracy in the teaching of our therapeutics has made the way easy for the makers of elegant pharmaceutical preparations to approach our practitioners. And "all that pertains to the great field of medical learning"

easily and almost unconsciously displaces the "special knowledge of homœopathic therapeutics."

I do not wish to be pessimistic, but the character of the papers presented before our national, state and local organizations demonstrates that the attention of our best practitioners is being occupied more with the important collaterals than with specific therapeutics: and my plea is the urgent necessity of a more careful study of drug-action on homœopathic lines if true scientific progress is to be attained.

Bishop Potter, of New York, in an admirable address delivered in Buffalo not long ago, emphasized the fact that Bigness and Greatness are not synonyms.

We have in the United States perhaps between twelve and fifteen thousand practitioners, among large numbers of whom there is nothing in their daily practice that warrants their segregation into a discrete body. If, therefore, we eliminate all that which we possess in common with the representatives of general medicine, and to which we have made no notable additions, and there remains only that which is peculiar to our practice, and to which we have also added nothing, the mere fact of numbers is not an element of strength, and our foundations are not as surely grounded as they were before our methods had become so catholic.

A POSSIBLE ALLY.

BY FRANCIS W. BOYER, M.D., POTTSVILLE, PA.

(Read before the Schuylkill and Lehigh Valley Homœopathic Medical Societies, June 27, 1900.)

SINCE the beginning of this century it has become more or less a habit to review the progress of the last century and to prophesy that of the coming one. A general review would be irrelevant to the present occasion, so we shall only summarize by calling to mind the inventions of the past fifty years which have been so decided in their character that they have revolutionized our systems of transportation and industrial methods. We have grown accustomed to frequent and radical changes along these lines. In the lifetime of most of us has occurred

the practical application of electricity. When New York proposed to use electricity as a motive power, many of us remember the "I don't believe it can be done" attitude of many people who now daily make use of the realized fact. So wonderful have been the results of this one development that the lesson of the past century has been to hope for all things and to doubt nothing. This rapidity of change in physical conditions must naturally affect the mind of man as distinctly as his body. We are not surprised, therefore, to find people beginning to think more rapidly. Consistency may still be a jewel, but a jewel whose market value has greatly lessened. Long-cherished views are ruthlessly dispelled. Indeed, each change of environment induces a corresponding action in the intellectual world. Rapidity of thought is the characteristic of the beginning of this age.

We cannot expect that the profession of medicine shall alone be unaffected by this restless grasping after more forceful results. The Genius of medicine joins the eager crowd of investigators, and for fear of losing an improvement often receives as true what is simply an innovation. Now, the physician is above all a man of facts. The theorist is out of place in the ranks of practitioners. The physician's creed is that of Thomas: "Unless I see, I will not believe!" It would be well for the world if, like Thomas, he would be open to conviction and be ready to turn from the doubter to the earnest confessor.

The ancient navigators drew maps of the world, and at the Straits of Gibraltar wrote with the conceit of ignorance, "*Hic deficit orbis!*" (here ends the earth). We laugh at their geography, and then proceed with a school-boy's chalk and string to enclose our views on theology, on medicine, on all subjects, in fact, with chalk-lines, and mark them with the same words, "*Hic deficit orbis!*" In a short time we either grow or some one jostles us, and our feet are compelled to cross the limits of the position we have given ourselves. To our surprise, we find we are still on solid ground, and on looking into our limited area from the outside we see how very small it was. Suppose we stand inside the medical line of the years that the oldest of us can remember. There is with us a limited number of dark-colored and nauseous concoctions and a lancet for bloodletting.

There is room inside the line, too, for the surgery of that day, and the remaining space is heaped up with "Don'ts."

Don't let fresh air into a sick-room.

Don't give a fever patient a drink of water.

Don't, on any account, bathe a patient.

Don't give a helpless infant any liquids but herb tea and castor oil.

Does not the course of events remind you of Æsop's fable of the barnyard where the cattle dwelt in perfect harmony until one ox turned around. Perhaps he saw an inviting pasture and meant to tell his neighbor. The point is, he turned around, and in doing so jostled the ox next to him because the yard was so small. This ox, thinking the accident was an attack, turned to retaliate, and in so doing jostled *his* neighbor, and so on, until the barnyard was in an uproar because one ox had turned around. This was the fate of one who turned around in the medical profession of years ago, so those who saw over the wall vaulted it and left the barnyard.

At the time of the first enclosure of medicine, while remedies were few, the few were given with lavish generosity. Drugs were then at the high-water level. If drugs proved ineffective, then bloodletting, or both at once, were tried. Parenthetically, notice the expressions *try* and *use*. During this time, by accident or otherwise, some one found that bathing a patient not only relieved him, but often cured some diseases by relieving discomfort, lowering temperature and inducing sleep. (Those of you who have given an ice-bath to a patient in the country can imagine the consternation.) With the enthusiasm of discovery, the advocate of bathing concluded, since this treatment relieved so much distress, it would relieve all, so he stepped out, circumscribed another area, called it water-cure, and announced "*Hic deficit orbis!*" He abused the inside area as heartily as the inside area abused him, and kept to the narrow space between the two perimeters. After a few years these contending factions took out the best methods from each and trod out the chalk-line, and were both stronger for the exchange.

Then came the discovery of electricity, with the same result; another chalk-line discarding both drugs and water-cure, a claim to heal by this power alone, and in time another blend-

ing. A reflecting person can see that one extreme produces a correspondingly opposite one, and then usually follows a scientific reconciliation. Our own school at first, in recoiling from the early violent methods, failed to recognize the importance of adjunct treatment until we learned to distinguish a palliative from a remedy. In passing, we might say it would be as well for us not to pick up missiles that have been thrown at us to hurl at some one else. So far all the boundaries have enclosed visible means of cure, drugs in either large or small doses, lancet, wet pack, battery, or other physical agent. Bear this in mind, please, for there is now another line drawn with the usual claim, "Here ends the earth!" We will look out to see the nature of this ground, and then step out and look back at our own position.

Whether we acknowledge it or not, there is a large and increasing number in this circle disclaiming the use of all drugs and material remedies for disease, and from the outer edge of the circle comes a voice denying the very existence of disease itself. We have all joked at their expense; few of us have thought it worth while to examine their methods, but have done as our predecessors did—ignored, ridiculed, persecuted.

As we look out from our standpoint, we say a school without drugs is ridiculous. How can you cure without a dose? In reality we apply Falstaff's comment on honor: "Can honor set to a leg? No. Or an arm? No. Or take away the grief of a wound? No. Honor hath no skill in surgery, then? What is honor? a word. What is that word, honor? Air. Therefore, I'll none of it."

If, in the same critical spirit we step outside and look back, we shall see diseases classed by the entire medical world as incurable, others in which drug effects and symptoms are so confused that blunders are made involving the health and even the life of the patient. We see morphine, conceded to be deleterious, used to an alarming degree, a constantly increasing use of narcotics, anodynes and stimulants; and that great attention is given to the cure of disease and comparatively little to its prevention.

We hear mania, melancholia, etc., ascribed to functional brain disorders; the microscope reveals none in the brain tissues. We see people denying themselves all that makes life desirable in order to prolong life itself.

The company we are now in, understanding, and we must confess having sometimes been the victims of our limitations, boldly repudiate all drugs and systems of administering them.

Every sincere physician, of whatever school, is trying to effect the physical salvation of the race. In going along this road we meet another going the same direction, albeit in a vehicle of a strange pattern. Shall we run into him, litter the road with the wreck, impede our own progress, or "hitch on," join forces, throw out cumbersome baggage and both reach the end more quickly? Suppose we hail our fellow-traveller and ask him how he effects his cures, since he carries no medicine case. When we investigate this system of healing, we shall find much to learn, much to discard, and much to improve. We must not write "*Hic deficit orbis*" around our position, lest we shut ourselves out from powerful help.

First, we know their cures are frequent and marvellous, and that like ourselves they sometimes experience relapses and failures. We also know many intellectual people are enthusiastic members of their ranks.

In briefly considering their claims we shall not take the incoherent utterances of a few leaders, but the most tangible explanation of the basis upon which their cures depend.

"The most prominent and important methods of healing the sick now in vogue may be briefly summarized as follows:

1. Prayer and religious faith, as exemplified in the cures performed at Lourdes and at other holy shrines. To this class also belong the cures effected by prayer alone, the system being properly known in this country as the Faith Cure and the Prayer Cure.

2. The Mind Cure.—'A professed method of healing which rests upon the suppositions that all diseased states of the body are due to abnormal conditions of the mind, and that the latter (and thus the former) can be cured by the direct action of the mind of the healer upon the mind of the patient.'

3. Christian Science.—This method of healing rests upon the assumption of the unreality of matter. This assumed as a major premise, it follows that our bodies are unreal, and, consequently, there is no such thing as disease, the latter existing only in the mind, which is the only real thing in existence.

4. Spiritism, which is a system of healing based on the sup-

posed interposition of spirits of the dead, operating directly, or indirectly through a medium, upon the patient.

5. Mesmerism.—This includes all the systems of healing founded on the supposition that there exists in man a fluid which can be projected upon another at the will of the operator, with the effect of healing disease by the therapeutic action of the fluid upon the diseased organism.

6. Suggestive Hypnotism.—This method of healing rests upon the law that persons in the hypnotic condition are constantly controllable by the power of suggestion, and that by this means pain is suppressed, function modified, fever calmed, secretion and excretion encouraged, etc., and thus nature, the healer, is permitted to do the work of restoration.

Each of these schools is subdivided into sects, entertaining modified theories of causation, and employing modified processes of applying the force at their command. There is but one thing common to them all, and that is that they all cure diseases.

We have, then, six different systems of psycho-therapeutics, based upon as many theories, differing as widely as the poles, and each presenting indubitable evidence of being able to perform cures which in any age but the present would have been called miraculous.

The most obvious conclusion which strikes the scientific mind is that there must be some underlying principle which is common to them all. It is the task of science to discover that principle.

It will now be in order to recall to the mind of the reader, once more, the fundamental propositions of the hypothesis under consideration. They are:

First, that man is possessed of two minds, which we have distinguished by designating one as the objective mind, and the other as the subjective mind.

Secondly, that the subjective mind is constantly amenable to control by the power of suggestion.

These propositions having been established, at least provisionally, it now remains to present a subsidiary proposition, which pertains to the subject of psycho-therapeutics, namely: *The subjective mind has absolute control of the functions, conditions and sensations of the body.* This proposition seems almost self-

evident, and will receive the instant assent of all who are familiar with the simplest phenomena of hypnotism. It is well known, and no one at all acquainted with hypnotic phenomena now disputes the fact, that perfect anæsthesia can be produced at the will of the operator simply by suggestion. Hundreds of cases are recorded where the most severe surgical operations have been performed without pain upon patients in the hypnotic condition. The fact can be verified at any time by experiment on almost any hypnotic subject, and in cases of particularly sensitive subjects the phenomena can be produced in the waking condition. How the subjective mind controls the functions and sensations of the body, mortal man may never know. It is certain that the problem cannot be solved by reference to physiology or cerebral anatomy. It is simply a scientific fact which we must accept because it is susceptible of demonstration, and not because its ultimate cause can be explained.

The three foregoing fundamental propositions cover the whole domain of psycho-therapeutics, and constitute the basis of explanation of all phenomena pertaining thereto. It seems almost superfluous to adduce facts to illustrate the wonderful power which the subjective mind possesses over the functions of the body, beyond reminding the reader of the well-known facts above mentioned regarding the production of the phenomena of anæsthesia by suggestion. Nevertheless, it must not be forgotten that the production of anæsthesia in a healthy subject is a demonstration of subjective power which implies far more than appears upon the surface. The normal condition of the body is that of perfect health, with all the senses performing their legitimate functions. The production of anæsthesia in a *normal* organism is, therefore, the production of an *abnormal* condition. On the other hand, the production of anæsthesia in a *diseased* organism implies the *restoration* of the normal condition, that is, a condition of freedom from pain. In this all the forces of nature unite to assist. And as every force in nature follows the lines of least resistance, it follows that it is much easier to *cure* diseases by mental processes than it is to *create* them; provided always that we understand the *modus operandi*.

It is well known that the symptoms of almost any disease

can be induced in hypnotic subjects by suggestion. Thus, partial or total paralysis can be produced; fever can be brought on, with all the attendant symptoms, such as rapid pulse and high temperature, flushed face, etc.; or chills, accompanied by a temperature abnormally low; or the most severe pains can be produced in any part of the body or limbs. All these facts are well known, and still more wonderful facts are stated in all the recent scientific works on hypnotism. For instance, Bernheim states that he has been able to produce a blister on the back of a patient by applying a postage-stamp and suggesting to the patient that it was a fly-plaster. This is confirmed by the experiments of Moll and many others, leaving no doubt of the fact that structural changes are a possible result of oral suggestion."—*Hudson's Law of Psychic Phenomena.*

This new science of healing is too immature for us to sweep away the whole system. We, however, are safe in saying that like other schools, its advocates claim too much. At present men are not ready to act on the supposition that they are not sick, nor can any invalid safely defy all ordinary precautions in regard to diet, clothing and exercise; nor are we, as physicians, ready to abandon those remedies that experience has proven to be effectual. The "coming man" may use more liberty in this regard, but we would better not antedate his arrival.

These systems show gradually progressing steps as clearly as material medicine does. The first position is that the Almighty has power to cure disease; second, some especial persons are so endowed; third, that each has the power to heal himself.

Leaving unnoticed the absurdities, the underlying principle is, that mind is a potent factor in curing the body, and that mind is affected by outside conditions. There is no medical heresy in this view. Every truthful practitioner will acknowledge he acts upon this principle, even though he may not emphasize it.

Some of us have had nervous patients with a list of ailments that we can discern no organic complications to produce. The proper psychological terms for these is that they are *actual* but not *real*. There is usually no benefit derived from telling such a patient he has no disease. Any of us would be more apt to hold out a hope of cure through the visible remedies we use to that end.

When we prescribe change of air, we do not mean the surrounding conditions are poisonous, but that the unexplainable force we call vitality is increased by climatic change and that mental change is necessary, though it be only occupying another room.

Mineral springs owe much of their curative action to regularity of living; rest to the overworked, the social life of a hotel to the over-worried and the constant suggestion of improvement, by hearing of that of fellow-invalids.

When business men are sent to recuperate at German springs, our patriotic citizens exclaim with Naaman, the Syrian, "Are not the rivers of Damascus better than all the waters of Israel?" Overlooking the fact that the ocean of waters between them and their cares form as influential a curative agent as the number of pints of the waters they drink daily.

"No company" is a precaution against adverse suggestion. Each man here may confess for himself how many times he would have enjoyed chloroforming the attendants instead of the patient, who has been demoralized by them. On the other hand, we give an occasional hypodermic of water with the same result as one of morphine. Old-school physicians give bread pills with gratifying success.

When a patient suggests failure to us by saying he has no faith in attenuated medicine, we assure him we have all the faith that is necessary to have, thus suggesting faith in a cure without faith. None of these methods are deceptions. We simply recognize a mental barrier to recovery. Every poison has its antidote, every stimulant its depressor; so since there are mental conditions that produce disease, so there are mental conditions that cure disease.

Darkness is not a tangible fact, though we are conscious of it. It is the absence of light, a negation. Disease is called, then, the absence of health, not real, though actual, health being the normal condition of the body. Further, healing forces are the more powerful, as they move with nature instead of against it. Recognizing the power of mind over the body, psychologists have investigated the conditions that affect mind, and have tried to discover the laws of its control.

The material treatment of mental healers tends to produce equilibrium in the nervous system and in the circulation, and

could be used with profit by any one. The agents employed are those of nature—heat, air, sun, water. (I cannot, without being unpardonably tiresome, enter into details.) There is a Society of Psychological Research both in this country and in England. We may confidently expect practical assistance from its investigations.

Assuming mental healers are right in their premises, the next step is, there is no *organic* disease, but the location of disease is in the nervous system or in the circulation, and that these are degenerated by fear and anger. Under fear, include apprehension in regard to health, financial resources, bodily harm, social position, and so on. In short, lack of repose. Under anger, include passion, spite, envy, touchiness, wrongly called sensitiveness; in short, lack of mental food in the mind to sustain its own life.

If, on our return to our patients, we should find these causes of mental irritation eliminated, what favorable changes would the thermometer and sphygmograph record!

In the selection on psycho-therapeutics the author speaks of *objective* and *subjective* mind. Others use the terms *subliminal* consciousness and mind. A theologian might say soul and mind. The study of the relations of these two minds is so interesting that it is with difficulty we leave untrodden the byways of mesmerism, spiritualistic seances, clairvoyance, etc., and keep within the limits of mental therapeutics.

Among the ancients, Plato, many of the Christian Fathers, later, Dr. Brown-Sequard, and others, accepted the dual theory of mind. These men wrought out different conclusions, but recognized the prime fact.

The power called *objective* mind takes cognizance of the *objective* world. Its media of observation are the five physical senses, and is capable of reasoning by all methods, inductive, deductive, analytic and synthetic. Its highest function is that of reasoning. It is the function of the physical brain.

The *objective* mind is not controllable against reason, positive knowledge, or the evidence of the senses by the suggestion of another. You cannot persuade a man black is white, or that he is a dog, when you appeal to this mind. Reason, senses, etc., do not accept it.

The *subjective* mind takes cognizance of its environment by

means independent of the physical senses. It perceives by intuition. It is the seat of the emotions and the storehouse of memory, and, as the author read says, has complete control of the functions, sensations and conditions of the body. It is a distinct entity, having a mental organization of its own and capable of sustaining an existence independent of the body. According to popular definition, it is *soul* in distinction from mind. It performs its highest functions when the objective mind is in abeyance. It is unqualifiedly and constantly amenable to the power of suggestion. It accepts without hesitation or doubt every statement made to it. As it is incapable of inductive reason, it accepts an absurd statement, or one contrary to the objective experience, as readily as a reasonable one, and its reasoning is entirely deductive. You *can* persuade a man he is a dog if you can reach this mind. It will accept the statement and carry out that idea.

In natural sleep, or in that produced by opium, the objective mind is at rest, and the subjective mind rapidly seizes material from the storehouse of memory and builds a structure of dreams.

Hypnotism is conquering for the time being the objective mind. The subjective mind obeys the suggestion of another mind and produces the pitiful spectacle of the hypnotic stage exhibition.

As a last resort, hypnotism may be used for good, but it is too powerful and far-reaching to be employed unadvisedly or by any one who does not thoroughly understand its laws.

A subject cannot be hypnotized against his own will. If he determines beforehand that he will not perform certain exhibitions, those experiments will be failures. In this defeat is met the force of auto-suggestion.

Much to our disappointment, mental science has taught us little in regard to improving the condition of imbeciles and the insane, for the reason that such experiments are largely individual and are not reported. This would seem pre-eminently its province. We have, perhaps, a better understanding of the nature of insanity, namely, false suggestions from the objective mind. Incipient insanity may be better treated for this knowledge. Suggestive treatment is claimed to be very effectual in the cure of alcoholism, opium habit, and cigarette habit in boys,

and to be highly beneficial in reformatory institutions. We hope for further enlightenment on this subject.

Treatment by suggestion is not an anticipation; it is a fact. Both oral and mental suggestion is largely practiced in surgery and on other occasions when anæsthetics are generally used. We have as yet taken only a few steps toward mental healing, and those, we must confess, are in the dark. We *feel*, rather than *see* the way.

The steps have been the power of mind over the body, the power of one person's mind over that of another, the power of the objective mind over the subjective. Then another step, still in the dark, is the power of mind to annihilate space and to make suggestions to a distant person, properly called mental telepathy and used by Christian Scientists in giving absent treatment. It is claimed to have been effectually used in curing rheumatism, neuralgia, dyspepsia, bowel complaint, sick headache, torpidity of the liver, chronic bronchitis, partial paralysis and strabismus.

A belief in this power requires no more credulity than it did some years ago to believe the human voice could be heard at a distance of fifty miles. Our conditions of living are producing an alertness and tension of mind that perhaps can respond to mental vibration, as an *Æolian* harp answers the breeze that lightly touches its strings. We might consider, for a moment, upon what conditions the ability to employ mental healing depends: On the part of the patient, hope of cure and faith in the ability of the physician. Then a passive condition of mind which will produce relaxation of body and no adverse suggestion from other sources.

The physician must, on his part, have faith in the correctness of his diagnosis and treatment; not less knowledge, but more, than at present. He must individualize his patients, know the physical idiosyncrasies. He cannot depend alone on drugs. He must make a diagnosis of the mind of his patient, understand likes and dislikes, prejudices and habits of thought. He must understand when the mind needs quieting and when arousing, and how to produce these results. He must practice his profession for his patient's good and not primarily for his own income. A tricky doctor will never be a successful one, although he may sell many prescriptions. He must be able to

thoroughly control his own mental faculties, and to concentrate his thoughts at will. There must be no incoherence in thinking, but calm deliberation and distinct thought-forms.

Our business with the mind of a patient is to aid him in auto-suggestions of health by surrounding him with favorable conditions to that end. If the mental powers are too weak, then suggestion from our own mind. Reserve hypnotism as the last effort to force a perverted mind into proper channels.

There is nothing in the truths of mental therapeutics to call us out from either our church or our medical affiliations. The extravagancies will die a natural death.

Musicians tell us we cannot *hold* a false note, neither can a science exist that is based on a scientific falsehood. We need no chalk-line marked "*Hic deficit orbis.*" The earth is a globe and a line that bounds it must be a circle, which has no end.

The probable effect on medical colleges of the present pre-eminence of psychological study will be to place Hygiene on the highest and most important place, and to emphasize physiology more and pathology less; that is, to study health and not disease.

If we refuse to accept newly discovered truths because we must concede some theory we now hold, we shall find ourselves pushed aside, our methods revised from the outside world, for, as Oliver Wendell Holmes says, "Sir, until common sense is well mixed up with medicine, and common manhood with theology, and common honesty with law, *we, the people*, sir, some of us with nut-crackers, and some of us with trip-hammers, and some of us with pile-drivers, and some of us coming with a whish! like air-stones from a lunar volcano, will crush down on the lumps of nonsense in all of them, till we have made powder of them, like Aaron's calf."

TO DISGUISE THE TASTE OF QUININE.—For this purpose the following formula is given: Sulphate quinine 4.0, citric acid 10.0, simple syrup, syrup orange peel, $\bar{a}\bar{a}$, 10.0, distilled water 10.20.0. Of this mixture ten drops are administered in 50.0 of water, then 3.0 bicarbonate of soda added, and while the mixture effervesces the liquid is drunk.—*Muenchener Medicinische Wochenschrift*, No. 8, 1899.

EDITORIAL.

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SPECTACLES, OR HELPS TO READ.

EFFORTS have been made, and we suppose are still being made in some quarters, to give legal definiteness to the difference between an optician and an oculist, and, with the present widespread misapprehension of the rights and functions of government, to protect by legislation the "dear public" from being imposed upon by mechanical fitters of glasses to the manifest detriment of those claiming scientific qualifications. The optician is beginning to realize that he is not an oculist, and the more conscientious of the trade turn over to the latter all cases presenting anything abnormal or beyond their own simple means of correction. Others, however, install some M.D., with more or less (usually less) knowledge of the eye and its requirements, and "examine free of charge" all presenting themselves. That much discomfort and some little damage to the confiding public result from the efforts of these hybrids cannot be denied, but that they are the only ones guilty of faults based upon insufficient knowledge and experience cannot be affirmed. Of the many medical students annually graduating from the colleges there is usually a large number who take up "the eye" as their specialty; and even if a wise Providence mercifully prevents them from spoiling their bushel of eyes in unsuccessful cataract operations, it does not see fit to restrain their ignorant refracting work. The ignorance of the first and underlying principle as to the place and use of glasses obtaining amongst some of them, and to a greater extent, of course, amongst general practitioners, is almost beyond belief, while the assurance with which papers are contributed to the medical journals laying bare such ignorance is exasperating.

We were driven to these thoughts by the perusal of a con-

tribution on *The Spectacle and Eye-glass Habit*, an answer to it, and an answer to this answer, all appearing in the "Medical Record" of New York during the summer months, at a time when the meteorological conditions were in themselves sufficiently depressing. We will not waste time in criticising in detail, but will briefly state what in our view is the basic principle involved in prescribing glasses, the application of which will prevent all sins of commission as well as of omission.

In the first place, however, in order to satisfy those who think that the wearing of spectacles or eye-glasses is a habit, or a fad, or mere fashion, we grant that there are some who from vanity put on eye-glasses, generally plane or very weak spherical ones. With these we have nothing to do, but usually the services of the oculist are in demand to relieve some symptom, directly or indirectly traceable to the use of the eyes. There is, fortunately for the specialist, a tendency on the part of the general practitioner to refer to the oculist any case of obstinate headache or nervousness which has become impatient under his unsuccessful medical treatment, and the first task of the oculist is to discover whether and in how far the eyes are responsible for the symptoms. This can only be learned from a careful examination of the refraction of the eyes and of the strength of the external muscles. It must be assumed that any eye in which the dioptric apparatus, when at rest, does not focus parallel rays upon the retina is to be regarded as ametropic. Now it is not true, as contended by one of the writers referred to, that "if an eye is ametropic the focusing mechanism is proportionately strong and usually makes functional compensation." That this is *sometimes* the case is true, but we may not on that account refrain from giving assistance, either temporarily or permanently, where it is not. Herein lies the key to the whole situation. So long as the focusing or converging mechanism can be exercised so as to give distinct vision near or distant, without producing abnormal conditions, no glasses should be prescribed. An ametropia, no matter of what degree, unattended by symptoms near or remote, direct or reflex, should never in itself lead to the use of glasses. Glasses should only represent the amount of painful effort which the eye is obliged to put forth in order to obtain clear vision. Suppose the total hyperopia be found under the use of a mydriatic

to be corrected by a $+ 2D$, and after the effects of the mydriasis have worn off $+ .75D$ is necessary to give distinct vision, then we know that this eye is capable of making an effort equivalent to $1.25D$, and we merely supply the $.75D$ which measures the effort it could not make without distress. The amount of painless effort which an ametropic eye can put forth varies very much, according to the character of the ametropia, the structural strength of the focusing mechanism, the general condition of the patient, and the circumstances under which the eyes are to be exercised.

It is not, therefore, a question solely of structure, nor yet only of function, but of the exercise of a function by an organ the faulty construction of which can or cannot be compensated for by unaided effort. We are called upon to decide simply what amount of relief each individual requires at a particular time, in order that he may exercise his visual function without damage or discomfort. We recall the case of a child in whom a severe attack of diphtheria completely paralyzed the muscles of accommodation, so that for six weeks the full correction of a high degree of previously latent hyperopia by glasses for constant use was absolutely necessary, both for comfort and safety. At the end of that time the glasses were laid aside, since the hyperopia again became latent through the re-established powers of the muscles to overcome it without aid. The questions as to whether glasses are to be worn at all, whether constantly or only for near or for distant work, present no difficulty to those who have grasped the idea that glasses are merely to represent the amount of effort on the part of the patient which cannot be exerted without producing symptoms. This applies particularly to hyperopia and to all forms of astigmatism, although in high degrees of myopia, where the convergence necessary for near work gives rise to symptoms referable to the external muscles of the eyeball, the same fundamental principle holds good.

By holding fast to this underlying idea we will naturally be led in all cases to prescribe the weakest lenses which will relieve the symptoms. We thereby guard against the very common fault of weakening the powers of the eye by affording too much assistance by the glasses prescribed, and leave the way open for their possible abandonment where the conditions calling for their use may prove to be only temporary.

As the normal painless exercise of the function of vision, as said above, is dependent upon so many factors constantly subject to modification, from within, by conditions of the general system, and from without, by circumstances attending it, we cannot determine in any case positively how long a pair of glasses should continue to give satisfaction. We have had patients continue to use the same lenses for eight years with perfect comfort, while others, at the same age and with the same kind and degree of ametropia, have required a change within eighteen months. The proposition, therefore, that patients wearing glasses should report to their oculist at least once a year for re-examination does not seem altogether unreasonable, especially in view of the comfort and satisfaction to be derived from the use of carefully prescribed glasses. The eyes are surely as valuable as the teeth, and cannot, like them, be replaced, and yet many willingly run to their dentist every six months to have their mouths overhauled, who worry along with ill-suited glasses for months, and even for years.

WALKING WITH A RUPTURED PREGNANT UTERUS.—Schwartz reports the case of a woman who had been delivered two years previously by normal labor and puerperium. The day she applied to the hospital she had ridden in a wagon half an hour to the railroad station, thence an hour by rail, and from the station, half an hour distant, she had painfully come on foot. Inspection showed a transverse presentation with prolapsed arm and impacted shoulder, a dead and decomposed child. The patient was very anæmic, and stated that she had fallen on the street, striking the abdomen, and had felt the child sink down, after which foetal movements ceased. Two days after, offensive liquor amnii was discharged. A midwife found the arm prolapsed. A physician tried to turn it, but in spite of every effort failed, and the patient suffered much pain. In this condition she took the above-mentioned journey. Further examination showed the cervix tightly around the engaged shoulder so that the finger could not enter the uterus. There was a laceration in the vaginal vault extending up into the uterus and parametrium five inches, which was filled with foul fluid and coagulated blood. General sepsis was present. Total abdominal hysterectomy was performed. Foul blood mixed with coagula escaped from the peritoneal cavity when it was opened. The operation lasted twenty minutes and the patient stood it well. The uterus, when removed, showed a laceration on the left side, corresponding to the shoulder. The endometrium showed the yellow-green appearance of gangrene, and the child was decomposing. In spite of every precaution and the use of Marmorek's antistreptococcic serum the patient died from septic peritonitis on the third day.—*Centralblatt für Gynäkologie*, No. 25, 1900.

GLEANINGS.

THE PATHOGENESIS OF GOUT.—To the International Medical Congress at Paris Sir Dyce Duckworth, of London, presented the following conclusions :

1. Gout is a morbid condition dependent on an inherent vice of nutrition, which was manifested by an imperfect metabolism in various organs or parts of the body, presumably in the kidneys, and probably in the liver.

2. This trophic disorder or inadequacy led to the formation of uric acid, probably in excess, and to the periodic retention of it in the blood (gouty urichæmia).

3. Histology threw no light upon the intimate nature of this defect, which thus related to cellular potentiality, possibly under neurotrophic influence, and not, so far as was known, to structural alteration.

4. This textual disability, or a tendency to it, might be primarily acquired and also transmitted as a fault, thereby inducing from time to time urichæmia with gouty manifestations in the descendants.

5. In most instances under conditions which provoked it, and in some cases independently of these, attacks of gout might grow up and come to a crisis. Such crises were attended by an alteration in the solubility of the uric salt in the blood, whereby irritating crystals of sodium biurate were produced and precipitated in various parts of the body.

6. A paroxysm of gout, the site of its occurrence and its metastases were determined by nervous influences, probably dominated from the bulbar centre, and the local attacks alighted either in the joints or in textures which had been weakened or rendered vulnerable by impaired nutrition owing to past injury or overuse.

7. This central neurosis was an essential and transmissible feature in the pathogeny of gout, and pertained to the arthritic diathesis generally.

8. The urichæmia of gout was peculiar, and unlike that which was produced by other morbid conditions; but the occurrence of urichæmia in the gouty was by itself inadequate to induce attacks of gout.

9. Uric deposits in any part of the body might be removed in the course of time, but were apt to be permanent in the least vascular tissues.

10. Uric deposits might occur to an enormous extent in gouty persons without the occurrence of any pain or paroxysms.

11. The clinical features of gout indicated that both *hæmic changes* (due to inherent morbid tissue metabolism) and a *neurotrophic disturbance* acted as pathogenic factors, and consequently gout was to be regarded as a neuro-humoral malady.—*Phila. Med. Journal*, August 25, 1900.

F. Mortimer Lawrence, M.D.

THE ETIOLOGY OF APPENDICITIS.—Morris, of New York, in an address before the Cleveland Medical Society, stated that the cause of appendicitis was anything which produced a break in the guarding epithelial cells in the

mucosa of the appendix. The break is a gateway through which the bacteria enter the lymphoid structure and a swelling of the lymphoid coat occurs. The guarding epithelium may be broken by a concretion causing erosion, by a sudden twist of the appendix upon its long axis, by the action of the psoas muscle, or by the desquamation of epithelium which occurs in typhoid, in simple colitis, and in many of the catarrhal affections of the colon. The important point is that the lymphoid coat cannot swell much without cutting off its own circulation, for it is confined within a narrow sheath of muscularis and peritoneum. If the latter becomes tight enough, gangrene ensues.

Gangrene occurs in several ways. When its own swelling has brought about a compression-anæmia of the lymphoid coat, the leucocytes cannot enter there to repel the attaching bacteria. In the appendix the warfare continues until the leucocytes, if not able to overwhelm the bacteria, are themselves destroyed. Then the bacteria in turn may come to an end in one of several ways. In the cases which terminate in so-called resolution, the bacteria, being walled in, are killed by their own toxins. Then, however, their spores remain, ready for development when favorable conditions arise; it may be a week, a month, a year or ten years, but generally it happens within a year.

Again, in a certain proportion of cases there is sufficiently good capillary circulation to allow the polynuclear leucocytes to destroy the bacteria as rapidly as they develop and to carry them away. The infective process comes to a standstill, and nature absorbs the products of the infection.

In most cases, however, one attack of acute infective appendicitis occasions an ulceration of the mucosa, and a scar results, which in time contracts and closes the lumen of the appendix at one or more points. Morris has found a mucous inclusion in upwards of 80 per cent. of all cases in which the patient has had one or more attacks.—*Cleveland Journal of Medicine*.

F. Mortimer Lawrence, M.D.

ADONIDIN IN HEART DISEASES.—In *Merck's Archives* (May, 1900) Stern studies the action of adonidin in heart diseases, which in rapidity, certainty and permanency of action he considers superior to digitalis. Its diuretic action in health is similar to that of the latter remedy, but in certain affections of the kidneys and in pyretic conditions it is much more effective. There is no record of any fatal effect on man.

F. Mortimer Lawrence, M.D.

ELECTRICALLY-DIFFUSED FORMALDEHYDE IN THE TREATMENT OF PULMONARY TUBERCULOSIS.—At the International Medical Congress in Paris three papers were read dealing with the discovery attributed to M. Francisque Crotté, of a cure for tuberculosis by the transfusion of microbe-destroying drugs passed through the chest and lungs by means of electric currents. The conclusion of the three reports, endorsed by Prof. Virchow, of Berlin, and Dr. Brouardel, of Paris, was most emphatically in favor of the new treatment.

The report says that since M. Crotté communicated the theory of his discovery to the French Academy of Science in 1894, eight hundred tuberculous patients in France have been treated by his method and six hundred of these have been completely cured. The number of patients whose treatment has been set forth in detail by the reporting physicians is thirty-two. All the

cases are divided into three categories: first, patients who are in the first stage of tuberculosis; second, those who have reached the second stage; and third, those who have reached a stage so advanced that under ordinary circumstances they would be considered incurable. The statistics submitted to the congress show cures amounting to 100 per cent. in the first class, 75 per cent. in the second, and 30 per cent. in the third.

Elaborate experiments have been made with rabbits and guinea-pigs to prove the exact quantities of formaldehyde transmitted to the tissue of the lungs by the application of the electric currents, and also to show how the intensity of the transfusion can be regulated. The method of treatment is simple. The patient is placed in the isolated chair of the static machine, and towels saturated with a solution of formaldehyde are applied to his chest and back. The solution varies in strength from 1 to 10 per cent., according to the degree of the disease and the patient's constitution and temperament. The machine is then started and a current with effluvia, or with sparks, or with both, is passed through the lungs. While this is going on the patient inhales the formaldehyde with electric effluvia obtained by placing a saturated sponge in contact with one of the poles of the instrument.

Dr. Crotté's method of treatment was tried in St. Luke's Hospital last winter but failed to meet the approval of the physicians after several weeks' test. The conclusion reached was that, while no hurtful consequences could be detected, there had been no conspicuously beneficial results. The discrepancy between the two reports is so marked that further experiments will undoubtedly be tried.—*Med. Times*, October, 1900.

F. Mortimer Lawrence, M.D.

METHYLENE BLUE IN URETHRITIS.—Methylene blue is best given in gelatin capsules in 1-grain doses three or four times a day. After the fourth day the dose may be reduced to twice a day. Given alone it sometimes causes irritation of the neck of the bladder, but when combined with oil of nutmeg there is no trouble of this kind. Oil of sandalwood is a desirable adjuvant because of its diuretic action, and also on account of its sedative effect upon inflamed mucous membrane. Recent observations show that, when given internally, methylene blue appears unchanged in the urine within two hours. By giving four one-grain doses of methylene blue daily there is always enough of it in the urine to kill all the germs it comes in contact with. This is irrigation "from above," irrigation, not of the urethra alone, but of the entire urinary tract. By this method of irrigation there is no danger of forcing the infection into remote recesses of the genito-urinary organs. Troublesome gastric symptoms sometimes follow the administration of the methylene blue of the shops, but with the following formula, put up in elastic capsules, uniformly satisfactory results have been obtained:

R. Methylene blue,	.	.	.	.	.	.	.	.	.	1 grain.
Oil of nutmeg, ,	.	.	.	.	.	.	.	.	.	1 drop.
Oil of sandalwood,	.	.	.	.	.	.	.	.	.	2 drops.

The above formula should not be used for more than ten days without intermission, and while giving it the patient should be instructed to drink freely of water.—*Med. Times*, October, 1900.

F. Mortimer Lawrence, M.D.

THE ÆTIOLOGY AND CURE OF HYSTERIA (Walter, Perry, Mo.).—If a massive culture of the colon bacillus, the original colony of which was taken from a non-infectious source, be administered to a case of hysteria—that is to say, of the active or convulsive type, latent or post-hysterical phenomena, such as paralysis, being excluded—the symptoms disappear in from twenty-four to forty-eight hours, and the patient is restored to health so far as the hysteria is concerned; debility or neurasthenic phenomena may remain for an indefinite period.

This same bacterium is already present in the dejection of every hysteria patient; then why should the administration of more cure instead of aggravate the symptoms?

Either one assumes the existence of a specific organism causative of hysteria not to be differentiated by our present method from the bacillus coli communis, or that, in the intestinal tract of predisposed subjects, the otherwise harmless colon bacillus may take on toxic properties.

In either event the offending organism is simply displaced by the method of treatment here advocated.

From the stomach or intestinal mucus of the hog, or from the dejection of the same animal, or barn-yard fowl, a colony is isolated by means of the agar plates, then removed to an agar test-tube, from which future massive cultures may be made. The latter may be made on the surface of agar Petri dishes. When the growth is well developed it may be scraped off, suspended in water or mixed with some indifferent substance, as starch, and administered in capsules. The growth on one Petri dish makes from three to six doses. This given three times a day will prove sufficient. The growth must be fresh. Results may confidently be expected in hysteria, but none in neurasthenia.—*New York Medical Journal*.

Herbert P. Leopold, M.D.

THE ÆTIOLOGY OF ACUTE PNEUMONIA (Howard, Cleveland).—This paper was based upon the study of 174 consecutive autopsies; in 67 of these there was acute non-tubercular lung inflammation. Of these 23 were primary and secondary croupous pneumonia, and 44 were primary and secondary broncho-pneumonia. In all there were 14 cases of primary pneumonia and 53 secondary pneumonia.

The pneumococcus was found in all cases of primary croupous pneumonia, in pure culture 8, with the streptococcus pyogenes in 1, and with the bacillus mucosus capsulatus in 1. In the 13 cases of secondary croupous pneumonia the pneumococcus occurred alone in 6 cases, streptococcus pyogenes alone in 2 cases, streptococcus pyogenes and staphylococcus aureus in 2 cases, streptococcus pyogenes and bacillus mucosus capsulatus in 1 case, streptococcus pyogenes and bacillus coli in 1 case, and bacillus mucosus capsulatus in 1 case in pure culture. Thus the pneumococcus occurred alone in nearly 50 per cent. of the secondary croupous pneumonia, while the streptococcus was concerned in the same number, but occurred alone in only 2 cases.

It was found that 1 case of broncho-pneumonia was due to the pneumococcus alone, 1 to the pneumococcus and bacillus of influenza, and 1 to the streptococcus and staphylococcus aureus. In the secondary broncho-pneumonias the pneumococcus occurred alone in 8 cases, with the staphylococcus pyogenes aureus in 2 cases, with bacillus coli in 1 case, and with streptococcus and bacillus mucosus capsulatus in 1 case; the streptococcus pyogenes occurred alone

in 4 cases, with staphylococcus pyogenes aureus in 1 case, with bacillus mucosus capsulatus in 1 case; the staphylococcus pyogenes aureus occurred alone in 3 cases, with the albus in 1 case, and with the pneumococcus in 1 case.

The bacillus mucosus capsulatus occurred alone in 7 cases, with bacillus coli in 2 cases; bacillus coli occurred alone in 2 cases, with "cocci" in 1 case and with pneumococcus in 1 case.—*Cleveland Journal of Medicine*.

Herbert P. Leopold, M.D.

STRICTURES OF THE (ESOPHAGUS (Bunts, Cleveland).—This writer divides strictures of the œsophagus as follows:

1, acquired diverticula; 2, strictures due to malignant growth; 3, strictures due to ulceration; 4, strictures due to traumatism.

Acquired diverticula are probably caused by some inherent or acquired weakness of the œsophageal wall, or by some form of obstruction causing unusual straining in swallowing, thereby causing a gradual dilatation. The treatment consists in removing the obstruction, and then removal of sack by operation.

Strictures due to malignant growths—these are almost always epitheliomatous—occurring usually in the lower third.

If an œsophageal bougie is passed it must be undertaken with great care, to avoid possible perforation of the soft tissue or hæmorrhage from a ruptured vessel.

The next two groups of strictures—those caused by ulceration or traumatism. These are treated by gradual dilatation by means of a series of gradual double-bulbed olive-pointed bougies—the first bulb being one size of the French scale smaller than the second. This serves to permit the immediate passage of a size larger. Great care and gentleness are required. If unsuccessful after repeated attacks in one day it is better to wait a day or two (if the state of the case permits) and then try again. On inserting the bougie it is best to have the patient sitting in an upright position with the head thrown back. Instead of passing it in the median line it is probably better to pass it into the pyriform sinus at the side of the larynx, with its funnel-like aperture, allowing the bougie to slide into the œsophagus.—*Cleveland Journal of Medicine*.

Herbert P. Leopold, M.D.

POISONING BY BOOTS DYED BY ANILIN.—Profs. Landouzy and Brouardel reported to the Académie de Médecine of ten children who, formerly wholly well, were seized with cyanosis and coma, after having on a hot day worn boots which had been dyed by anilin. Experiments on guinea pigs with this same chemical led to similar symptoms, and even to hæmoglobinuria. Although three of the cases were very severe they all recovered. Dr. Blache referred to a similar case of anilin poisoning after wearing colored stockings.—*Muenchener Medicinische Wochenschrift*, No. 35, 1900.

Frank H. Pritchard, M.D.

THE DANGERS OF THE GAS OF CHILDREN'S BALLOONS.—Dr. Vallin calls attention to the danger of the little red toy balloons which are sold to children in toy shops. The alliaceous odor leads him to think that they contain arseniuretted hydrogen, which easily spreads through the air of the room where the balloon may be, though this is denied by Prof. Brouardel, who asserts that illuminating gas is chiefly employed in filling them, and that the garlicky odor is due to an admixture of acetylene gas.—*La Semaine Médicale*, No. 36, 1900.

Frank H. Pritchard, M.D.

ARSENIC IN PERNICIOUS ANÆMIA.—Dr. W. Warfvinge, of Stockholm, in the course of twenty years of hospital practice has been so fortunate as to observe and follow fifty-three cases of pernicious anæmia. Some of these were observed before arsenic was employed in this disease or too late, and thirty-six are fully illustrated by clinical histories. He asserts that, like mercury and the iodide of potash in syphilis, we have in arsenic a specific remedy for this disease. In all cases where it was methodically used a turn for the better was noticed. Sixteen of these patients died, after one or more recurrences of various complications. The remainder remained well as far as they could be followed. Although the fate of the patients, one or two years after leaving the hospital, was not known, yet it seems that these data show what a powerful remedy we have for this disease in arsenic.—*Nordiskt Medicinskt Arkiv.*, No. 19, 1900.

Frank H. Pritchard, M.D.

ASTHMA AND PREGNANCY.—Dr. Audebert read a paper on this subject at the meeting of the gynæcological section of the International Medical Congress recently held at Paris. It may be a very serious complication. So far only five cases have been published, and to these he adds two. It increases in intensity during pregnancy, the attacks being particularly violent and dangerous. The outlook is especially serious for the mother (one death in seven cases), as well as for the children (two deaths out of seven cases). The dyspnœa even if very violent does not cause contractions of the uterus. As to remedies, morphine and quinine have been used; the child should be extracted as soon as it is viable.—*La Semaine Médicale*, No. 36, 1900.

Frank H. Pritchard, M.D.

DIAGNOSIS OF TRUE FROM SYMPTOMATIC ASTHMA.—Prof. J. Vires directs attention to the diagnostic and prognostic importance of making a correct diagnosis in asthma and allied states, for in the former the outlook is practically always favorable, while in uremic and cardio-vascular affections the prognosis is vastly different.

In true asthma three facts impress one :

The dyspnœa is paroxysmal; there is bronchial exudation and associated pulmonary emphysema. At first the physical signs are normal, yet by repeated attacks one finds excessive and diffuse sonorousness of the thorax on percussion and diminished respiratory murmur on auscultation, with sibilant râles. The right ventricle hypertrophies, the general circulation stagnates, with resulting venous stasis, hyposystolia, passive congestion of the liver, ascites and cutaneous œdema.

The general nutrition suffers; the face, at first pale, becomes cyanotic, the eye-balls protrude and the facial expression is that of suffering. Therefore, three stages mark its evolution: the nervous, the catarrhal and the emphysematous periods.

Asthma may simulate capillary bronchitis. Here several symptoms help to distinguish. A sense of suffocation coming on all at once is not due to an infectious disease; the temperature is not above 37.5°; the respiratory rhythm is reversed, for inspiration is difficult, short and forced, while expiration is incomplete though longer than normal. The vesicular murmur is absent; the breathing blowing, noisy, accompanied by expiratory sibilant râles, which later become humid. The number of respirations is, in spite of the

oppression, less than in health; the lungs are, as it were, immobilized in the thoracic cage. The cough is at first dry, tickling, with scanty, glutinous and pearly sputum. The patients tell facts pointing to a gouty, neuropathic or arthritic ancestry. So much for the diagnosis of *true* asthma.

Uremic asthma should not be forgotten. Such a one will present no prolonged, blowing expiration, with inversion of rhythmic respiration. There will be œdema and gallop-murmurs. There are still two others of importance, which are, however, not constantly present: Cheyne-Stokes breathing and albuminuria. The lesser signs of Dieulafoy should also not be forgotten: large, hardened and serpentine temporal arteries, frequent epistaxis, cramps, frequent desire to urinate, increased sensitiveness to the cold, roaring in the ears, transient headaches, blurring of vision, sense of formication, etc. In some cases the asthma is truly cardiac. Any little effort appears to bring the seizures on, they appear suddenly, and really never wholly cease, leaving him oppressed and exposed to another attack from the least cause. Auscultation shows inspiration to be shorter and expiration weaker than in true asthma. There is no blowing respiration, and at the bases breathing is both rhoncus and sibilant. The pulse is weak, depressible and arrhythmic. The heart presents aortic and mitral lesions. Aortic asthma is particularly serious, for the patient has an actual "hunger for air, which he seems to swallow more than to breathe." He suffers from pains about the sternum, vertigo, fainting attacks and heart failure.

Another form of asthma is that observed during acute miliary tuberculosis as well as during chronic phthisis.

In the miliary variety the dyspnœa is intermittent, nocturnal, progressive, which finally leads to asphyxia. This progressiveness with the fever serves to distinguish it. In the other variety the catarrh and emphysema hide the signs of tuberculosis. The attack is brought on by fatigue or emotion. The supraclavicular fossæ are pronounced, the first three intercostal spaces flattened by pleural adhesions. On auscultation there is no blowing respiration, the number of respirations is increased, there is dulness at the apices, while heredity and other personal signs, as hæmoptoe, hectic fever, emaciation, etc., help to confirm the diagnosis.

Asthma from empyema is detected by thoracic malformations, absence of supraclavicular and subclavicular depressions and broadening of the intercostal spaces. Auscultation and percussion will yield signs of capital importance. The general condition, the heredity, the personal history and the state of the pulse frequency will also aid. Hirtz calls attention to the symptomatic value of an intermittent fever appearing every four or five days.—*Rivista Critica di Clinica Medica*, No. 30, 1900.

Frank H. Pritchard, M.D.

A SPECIAL FORM OF CHRONIC ICTERUS.—Dr. Bettmann observed in Erb's clinic a young man of twenty-nine years who, since his youth, had been affected with chronic icterus. From time to time it would exacerbate, when the urine would become dark in color; they would be preceded by various disagreeable sensations, and be caused by excessive eating and drinking, psychic shocks, bodily over-exertion and cold. The liver was found to be normal, the spleen hard and greatly hypertrophic; no ascites. The urine contained no albumin, sugar, bilirubin, urobilin or hæmoglobin. The fæces were of a normal color; the hæmoglobin 75 per cent., the chromocytes 4,216,000, leu-

cocytes, 8800. The erythrocytes easily disintegrated mechanically, and the serum showed a tendency to dissolve foreign bodies. Once hæmoglobinaemia, and at another time hæmoglobinuria, was noted after an attack. He regards the disease as a hæmoglobinaemia. How near it is nosologically to the *ictère infectieux chronique splénomégalique* of Hayen he does not attempt to say.—*Weekblad van het Nederlandsch Tijdschrift voor Geneeskunde*, No. 8, 1900.

Frank H. Pritchard, M.D.

THE CAUSES AND TREATMENT OF MOVABLE KIDNEY.—Mansell Moullin (London) says: "In a very large number of cases of movable right kidney there is a definite flattening of the right lumbar region. This, of course, cannot possibly be due to malposition, or even to absence of the right kidney. Behind the right kidney are the eleventh and twelfth ribs, and below the ribs are stout ligaments which pass from the transverse processes of the upper two lumbar vertebræ to those ribs. Absence of the right kidney can have no effect upon the contour of the back. In reality the flattening is a sign that the vertebræ have undergone a certain degree of rotation, and it is an indication of the cause of the displacement of the kidney, not a consequence of it. The width of the lumbar recesses is one of the penalties which have followed the assumption of the erect attitude. . . . The convexity forwards of the lumbar spine helps to make them still more shallow. The pelvis, especially in the female sex, becomes wider, so that the lower end of the recess becomes more open, and then, as a last straw, the development of right-handedness causes the transverse processes of the lumbar vertebræ which lie under the floor of the right recess to be thrust forward. From a position of the greatest safety the kidneys are placed in one from which almost all security has gone, and it is not to be wondered at that comparatively trivial causes, such as an increase in the weight of the organ, without a corresponding increase in bulk, a sudden violent jerk, or a great lowering of the intra-abdominal pressure, can increase their normal range of mobility and force them downward. The wonder is, not that movable kidney occurs, but that it does not occur more often. . . . It is certainly hereditary, and it is common. It is present in women much more often than it is in men, and in women who have borne children more often than in those who have not. It is also at least twenty times more common on the right side than it is on the left side. None of the other reasons which have been assigned for it, such, for instance, as the weight of the liver, or the length of the renal vessels, is sufficiently probable to deserve consideration."

In the treatment of movable kidney, the choice lies between wearing an abdominal belt and nephrorrhaphy. A belt is indicated only in those mild cases where the organ is but slightly displaced from its bed. It does not press the kidney back into place nor retain it there when the patient is upright. It simply braces the abdominal viscera together, and so steadies the organ. Pads are useless. In the more severe cases, or when belts have failed to accomplish their object, nephrorrhaphy is to be recommended.—*The Lancet*, May, 1900.

Gustave A. Van Lennep, M.D.

A NEW METHOD OF OPERATION FOR EXTROPHY OF THE BLADDER.—Beck (New York) reports an improved "autoplastic method" for the relief of this deplorable deformity. The object of the operation is an attempt to restore the retentive power of the bladder by supplying it with an anterior

muscular wall. The margins of the protruding bladder-walls are freed, and the recti muscles exposed and severed from their insertion at the pubes, and also partially from the transverse fascia, until they become so far mobilized as to be readily reflected and united, thus forming an anterior vesical wall. This method was further modified in a second case, in that flaps consisting of muscular fibers were made by incising each rectus muscle along its internal margin to the extent of little less than half its thickness. Two transverse incisions, connecting the outer and inner margins of each rectus, and extending down into the substance of the muscle to the same extent, completed the outlining of the flaps. The lower incision was just above the symphysis pubes, and the upper just below the umbilicus. The flaps thus formed were "undermined," beginning at the inner border, until they could be lifted near the outer margin, remaining attached at this point after the manner of a hinge. The bladder-walls were first united with silk sutures, then the reflected muscular flaps were united over this, and the integument also closed over the muscular layer with subcutaneous and relaxation sutures.

The author claims that in this manner he was able to obtain a small but virtually normal bladder protected by a firm muscular layer. The epispadias groove is corrected at a subsequent sitting by Thiersch's method.—*New York Medical Journal*, August, 1900.

Gustave A. Van Lennep, M.D.

THE VALUE OF PEDICLED FLAPS IN INJURIES OF THE HAND.—Schroeder (Chicago) reports some very instructive cases of lacerated and contused wounds of the hand treated by means of large pedicled flaps obtained from the hip and abdomen. The author points out that elasticity and resistance are required of the skin in the palm of the hand, and neither of these conditions is furnished by the Thiersch or Reverdin, or even the free-flap method, although these methods may be used successfully on the dorsum of the hand. Flaps to cover the palm, dorsum of hand, or the palmar surface of the thumb, may be obtained with freedom from the chest or abdomen. Where the palmar surface of the fingers has been destroyed, it is much better to have double pedicles, and these can best be obtained from the hip. The hand and entire arm can be readily immobilized to the side by means of a plaster-of-Paris dressing. A trap-door is cut in this, through which the wound is dressed. The position is reasonably comfortable, but is not justifiable in the young or the old.

The author reports, in all, four cases in which this method of filling-in defects was successfully carried out. The most extensive operation of the series was undertaken for the relief of a badly contracted hand, following a burn. The cicatricial tissue, which occupied the entire palm and the palmar surface of the fingers and thumb, was dissected away down to the tendons. This large raw surface was then covered by means of double-pedicle flaps taken from the hip. As fast as these flaps "took" they were divided from their attachment and stitched to the skin margin of the hand. The large raw surface left on the hip was covered by Thiersch grafts taken from the thigh. A good serviceable hand was obtained. In cutting the flaps the author recommends that at least a quarter inch of the subcutaneous tissue must be taken with the skin, else its vitality is endangered. There must be no tension on the pedicles.—*The American Journal of the Medical Sciences*, Oct., 1900.

Gustave A. Van Lennep, M.D.

MAUNSELL'S END-TO-END INTESTINAL ANASTOMOSIS. (Emmet.)—Catch the two ends of intestine by a stitch in the lower part of each gut against the mesentery, including the mesentery, and do the same at the top, leaving the stitch long, after tying it. On the proximal or distal side make a slit or buttonhole one and a half or two inches from the excised end. Pass a forceps through the buttonhole and catch the two threads, one binding the top section, the other the lower. Then drag upon them. The two ends of the gut are face to face, and are dragged through the buttonhole, inverting one, the other following. There are now two serous surfaces edge to edge, make union at that point a quarter of an inch below the border, putting in eighteen or twenty through-and-through sutures, dividing in the middle, tying them, and cutting as you go. When this union is made, work down and draw the gut into its old place, stitch the buttonhole, wash off the gut, close the abdomen, and the patient should recover. This operation is reported by Wiggin, in the *Medical Journal* of Dec., 1895.—*American Journal of Obstetrics*, May, 1900.

George R. Southwick, M.D.

THE EXTRACTION OF A LIVING CHILD NINETEEN MINUTES AFTER THE DEATH OF THE MOTHER.—Kirch reports the following remarkable case. The patient had suffered a number of years from mitral insufficiency and was at the end of her seventh pregnancy suffering from œdema, scanty urine, irregular pulse, dyspnoea and other symptoms of non-compensation. He was sent for in a hurry, with the statement that she had died at the birth of the child. He found the new-born child in the care of an old woman, and the patient dead on the bed with foam dripping from the open mouth. A foot of a second child projected from the vulva, which he delivered easily, and after some time he was able to resuscitate it, though the child died some hours later. The mother died from œdema of the lungs.—*Centralblatt für Gynäkologie*, No. 25, 1900.

George R. Southwick, M.D.

THE CONSERVATIVE TREATMENT OF SUPPURATING TUMORS OF THE ADNEXA (Dührssen).—A diagnosis of a parametric exudate is made too often when really the tumor contains pus, especially when it is preceded by labor or some operation. A true parametric exudate is generally a transitory disease. A so-called parametric exudate which still exists six months after labor is almost always a pyo-ovarium or a pyosalpinx.

The writer advocates posterior colpotomy, combined, if necessary, with ligating and dividing the cardinal ligament, as a safe and effectual method of treatment for emptying large collections of pus in the tubes, ovaries or adjacent structures. By this method seriously diseased organs can be preserved and relatively cured. It is also successful in the presence of severe complications, as when the collection of pus has perforated the intestine. It limits the indications for ventral cœliotomy and extirpation of the uterus.—*Archiv für Gynakologie*, Bd. 60, H. 3, 1900.

George R. Southwick, M.D.

A MODIFIED HYSTERECTOMY. (Davenport.)—The writer prefers to leave the cervix when practicable, and therefore the abdominal route is his operation of choice. His modification consists essentially in a high amputation of the corpus uteri, leaving the entire cervix, and perhaps the lowest segment of the uterine body, and not ligating or disturbing the uterine arteries. The

broad ligaments are clamped between the ovary and tube and the pelvic wall, ending close to the uterus just above the level of the internal os, with clamps close to uterus. The uterus, ovaries and tubes are removed above the lower clamps and the flaps of uterine tissue united with silk. It is not necessary to strip off a cuff of peritoneum, and the folds of the latter are sewn together in the usual manner. The advantages claimed are, shorter time of operation, without opening the layers of the broad ligaments, and excellent convalescence. —*American Gynecological and Obstetrical Journal*, July, 1900.

George R. Southwick, M.D.

DYSMENORRHOEA AND APPENDICITIS. (MacLaren.)—Besides the well-recognized forms of appendicitis, there is another form closely resembling dysmenorrhœa which shows itself as an appendical colic, recurring with each menstrual period, and apparently caused by the pelvic congestion accompanying each menstruation. It is confined principally to the right side. Such cases require careful examination before proceeding to treatment, which must be surgical. —*The American Gynecological and Obstetrical Journal*, July, 1900.

George R. Southwick, M.D.

HYSTERECTOMY.—Haughey, Battle Creek, Mich., from careful consideration of the condition of the woman after hysterectomy, presents his conclusions in the following propositions :

"1st. That her life will be shortened. If she survives the shock of the operation, manifestly her life will be lengthened and also made more tolerable, as she will be relieved of the diseased condition for which the operation was done, also all its concomitant nervous reflexes. Therefore, while she may not attain a ripe old age, she has a fair chance to live much longer and more contentedly and comfortably than she could with the diseased condition.

"2d. That she will become coarse and masculine. Does a woman become masculine after the menopause? and what is a hysterectomy but an earlier establishment of the menopause? It is simply in compliance with the general physiological law of nature, removing a part that is no longer useful or in use; the uterus and ovaries undergo atrophy after the menopause. Therefore, the natural supposition is that the organs are not used by the animal economy after that period, and it matters not whether this period is approached naturally or artificially induced. Nature's laws in this regard are not outraged, the woman's gender is not changed or varied, and she retains her femininity and is not more unsexed than is any woman who has passed the menopause.

"3d. That sexual passion and capacity will be obliterated. This is no doubt true in most cases as far as passion is concerned, yet we all know of many marked exceptions. However, the question is not worthy of serious consideration, because the diseased conditions that require the operation not only render her passionless, but make her physically incapacitated for sexual congress. Therefore, when coitus is rendered painless, or bearable at least, the condition is improved and the argument does not count." —*International Journal Surgery*, September, 1900.

W. D. Carter, M.D.

DIFFERENTIAL DIAGNOSIS OF UTERINE PREGNANCY, ECTOPIC GESTATION AND SOME ABDOMINAL TUMORS.—Dr. Muret calls attention to the excessive

flaccidity of the body and isthmus of the gravid uterus as susceptible of leading one into error in the diagnosis of extrauterine pregnancy. The cervix may in the first months remain hard, while the body or the isthmus becomes very flaccid. On palpation the atonic and flaccid uterine walls permit the foetus to be felt, as it seems, right through the abdominal walls, while the hard cervix is thought to be the corpus uteri; hence ectopic pregnancy is diagnosed erroneously. This excessive flaccidity is seen particularly from the fourth to the seventh months and is a transitory phenomenon. To diagnose, percuss to bring out the shape of the uterus, and try electricity to cause the uterus to contract down to the normal size and position (Engelmann), at the same time recalling the rarity of abdominal pregnancy compared with excessive uterine flaccidity which may be observed both in nulliparæ as well as in multiparæ. Excessive flaccidity of the isthmus of the uterus is at times, in certain cases, so confusing that the well-known sign of Hegar, the feeling of the cervix like the neck of a jug and the corpus like the jug itself, is confused in that the cervix is felt as a small uterine body and the uterus above feels to the examining hand as a cystic tumor seated above, and detached from the uterus. Then a diagnosis of extrauterine pregnancy is very easily made erroneously. There are two sets of cases: Those where there is a small and short cervix surmounted by a soft and cystic tumor without any palpable pedicle. Then again those with a very long (and hypertrophic) cervix which is joined to a tumor formed by the pregnant corpus uteri and connected by a pedicle, due to thinning and elongation of the isthmus of the uterus. Then the uterine globe is either to one side or behind the cervix. In these cases, differentially, it is well to note that the apparent body of the uterus appears to be *directly surmounted* by a cystic tumor.

Of the second class he reports four cases. Introduction of a sound in one produced abortion. One should keep in mind: 1. That palpation reveals sometimes the round ligaments attached to the sides of this cystic tumor, and at times the ovaries. 2. Contractions of the tumor indicate a gravid uterus, and the cyst forms a whole with the cervix. 3. The insertions of the uterosacral ligaments to the upper part of that which seems to be the corpus reveals that it is only the cervix. 4. Bi-manual exploration of the adnexa demonstrates their presence or absence at the sides of the uterus, and if they be absent alongside of that which is thought to be the corpus, it is then only the cervix. 5. In some cases drawing down the cervix with a volsellum enables one to recognize the relations better. Push the cystic tumor into the median line and the pedicle contracting reveals the relations between the supposed tumor and uterus. Another measure is to note that the pseudo-pedicle arises from the summit of the rounded cervix and not from the sides, and that often a second pedicle, the utero-ovarian ligament, is felt. He advises against introduction of a sound and thinks Hegar's sign here is of no value.

Anomalies of the gravid uterus—uterus bicornis, bilocularis, arcuatus or cordiformis.—Pregnancy in malformed uteri has often given rise to error. Extended observation and noting the position of the round ligament will assist diagnostically. If inserted at the external segment of the supposed tumor, the ovary is external, there are contractions in the foetal sac, with lack of pelvic disturbances at the beginning of pregnancy; a uterine pregnancy. —*La Settimana Medica*, No. 4, 1899.

SUGAR IN INSUFFICIENT "PAINS" IN PARTURITION.—Dr. Max Madelener has employed sugar in six cases of weak uterine contractions in childbirth. An active influence was noticeable after thirty to sixty minutes, in five out of these six cases. In these five spontaneous labor followed. At first, six pieces of loaf-sugar were administered, *i.e.*, about an ounce in half a cupful of water; if necessary, this dose was repeated. Two took larger doses then were ordered, 120 and 150 gms., without vomiting or nausea. If sugar alone is repugnant, one may give it in tea or with some rum. The general impression was that sugar favored an increased contractile power of the uterine muscle. He was led to use it on account of the seemingly favorable influence of sugar in relieving fatigue during Alpine tours.—*Muenchener Medicinische Wochenschrift*, No. 34, 1900.

Frank H. Pritchard, M.D.

BLINDNESS AMONG THE RUSSIANS.—Statistics which have just been compiled show that of the 302,000 totally blind persons in Europe, 192,000 are natives of Russia, and this means that out of every 500 subjects of the Czar there is one who is deprived of sight. In no other country do we find this terrible affliction by any means so widespread. In Germany, France, Great Britain, Italy and Spain there is only one blind person in every 1000 inhabitants. Russian oculists and physicians say that the reason why so many of their countrymen are blind and so many others have defective eyesight is because insufficient attention is paid throughout the country to the ordinary laws of hygiene, and they maintain that Russians will continue to suffer in this way as long as they keep themselves and their homes in unhealthy condition.—*Ophthalmic Record*.

William Spencer, M.D.

THE PERCEPTION OF THE BLIND.—In the *Doctors' Magazine* for July is an article by Frederick Boyd Stevenson, giving an account of certain inmates of the Illinois Industrial Home for the Blind, who, though totally blind, possessed the faculty of recognizing objects, to a certain extent, without the apparent aid of the other senses. Thus, one could tell when he was approaching a tree or a curbstone, and could even recognize the different individuals in the room.

But if he were expecting to meet persons, he could not tell whether any one was in the room or not. Similarly, if the electric light was turned on unexpectedly he was aware of it, but if it was announced beforehand he could not recognize the difference. Attention or expectation seemed to destroy the peculiar perceptive faculty possessed by the individual, which seems, therefore, to depend somewhat on the untrammelled exercise of all the powers of unconscious sentience, or of some special as yet unrecognized faculty called into action by the deprivation of sight. This last is what is most readily assumed, but whether correctly is a question.

Stevenson adopts this view, and quotes some reported facts of somnambulism as being at least suggestively explanatory. Just how perceptions reach the conscious centres is not always clear, and there may be possibilities as yet unthought of. The case of the perception of light through the nose reported a year or two ago is in point.

It hardly seems necessary, however, to admit more, perhaps, than a sharpening of the unconscious sensory cerebration which we utilize in every movement and function, but which in the full use of our senses may not be called into action. This may not be an adequate explanation, but it suggests itself

as being as reasonable as any. The perceptions of the blind is a subject not yet fully exhausted by the psychologists.—*Jour. Amer. Med. Assoc.*

William Spencer, M.D.

THE LASTING RESULTS OF THE OPERATION FOR MYOPIA.—This is a very important question, and the one which chiefly interests us at this stage is that which refers to the occurrence of retinal detachments. In connection, then, with this point, I might refer to the statements of the author. He analyzes 184 cases which he operated upon during the last six and half years. He relates in detail the 11 cases in which he met with detachment of the retina. In 3 cases the operation can certainly not be regarded as instrumental in bringing about the detachment, as the patients enjoyed several years of good sight after the operation. In 2 of these cases a vitreous thread was incarcerated in the cornea, and this probably led to the detachment. In the other 6 cases it was impossible to directly trace the detachment to the operation.

The author then recalls the fact that retinal detachment is not infrequent in high grades of myopia even when no operation had been performed. He gives a number of statistics which bear upon this aspect of the question, and particularly a study of the cases seen in the eye clinic of Halle from 1884 to 1899.

It might be of interest to note the fact that in 54 cases where no operation was performed, retinal detachment occurred four times, that is to say a little over 1 per cent. oftener than when the operation was performed. The author then goes on to speak of the course of choroiditis in these cases—as to whether the disease is brought to a standstill by the operation, as some think; also as to the danger of glaucoma; all of which are points which have provoked not a little discussion and which need not be referred to here. It is evident, however, from his contribution, that he is a strong friend of the operation.—Prof. Von Hippel, Halle.—*Von Graefe's Archiv. fur Ophthalmologie.*

William Spencer, M.D.

THE THERAPEUTIC VALUE OF INSTILLATION OF QUININE IN SUPPURATION OF THE ANTERIOR SEGMENT OF THE EYE.—Gonzalez, Leon, Mexico, has of late employed this drug with success in suppurative cases of the cornea. In pus invasions of the anterior chamber, and in cases of iritis with hypopyon, he uses exclusively a 1 per cent. solution of neutral hydrochlorate of quinine. These cases were such as did not yield to ordinary treatment, thus obliging him to seek something different, and it seemed to him very rational, after considering the efficacy of quinine, to try its effect. When using a solution the patient feels a sharp burning at first, which rapidly disappears at the end of five minutes. It is well known that quinine affects the eye-muscle, which in itself encourages the re-absorption of the exudate; and in such cases where many teachers would use a myotic, quinine seems particularly valuable. The day after the use of quinine the infiltrated zone is less distinct and the abscess is smaller, the pus appears to begin to be absorbed, and the cornea clears until the ulceration has disappeared. Another therapeutic value of quinine lies in the sedative effect which it has in general on corneal inflammations. The author has been convinced of this fact many times; although the pain is increased at first, it rapidly subsides and is very soothing afterward. The antiseptic action of the quinine is not its only effect upon the cornea—it also prevents leucocytosis, as it inhibits the leucocytes in a solution of 1 : 4000.—*Annals of Ophthalmology.*

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

THE MEDICAL TREATMENT OF DIPHTHERIA.—Kern, of Lafayette, Ind., realizes the differences of opinion as to the method to be pursued in treating diphtheria. He is not opposed to the use of antitoxin, but nevertheless clings to the belief that homœopathy has specifics if the physician is willing to take the time to individualize sufficiently.

All authorities agree that some form of mercury stands first as the nearest simillimum to diphtheria, especially in its graver aspects. We owe our knowledge of the use of mercury to that eccentric, but at the same time eminent, physician, Dr. William Douglass, of Boston, who achieved great results from the use of heroic doses of calomel in the first epidemic of diphtheria in this country, in 1735. All are familiar with the famous case of poisoning in New York in which the illness simulated diphtheria, and was treated for that disease, and the patient supposedly died from the effects of it; but later it was discovered that death was due to poisoning with cyanide of mercury, which gives these symptoms: Tonsils covered with leathery patches; pulse feeble, intermittent, small, quick, and high—130–140; great prostration, pallid and sodden countenance; moist skin, saliva thick, tongue coated brown or black, pharynx and uvula covered with a dirty gray exudate; intense and threatening from the start; tendency to membrane formation; nares involved as well as pharynx; putrescence with foul-smelling breath and odor extending outside the sick room.

The *iodide of mercury* is especially adapted to strumous subjects, in whom the lymphatics are involved very early in the attack and the other symptoms are mild.

Mercurius corr. is indicated in the incipient stage and when prostration is not so great; very little exudate and all symptoms indicating a mild attack.

Kali bichromicum ranks high in the treatment of diphtheria, especially when there are laryngeal complications. In this form the mucous membrane is deeply affected and ulcerated; painful, difficult swallowing; stringy tough mucus; cough hoarse and metallic; exudation yellowish or yellowish-white in color, and of a firm fibrous nature, thrown off in large quantities, covering both tonsils and extending into nares and larynx.

Apis mellifica becomes efficient when there is dull red pharynx, swallowing difficult, the uvula œdematous and elongated, tongue thickly coated or thick and dry, particularly if patches of membrane are not heavy; stinging, dryness and burning in the throat; mucous membrane glossy and purple; œdematous swelling of the face and neck; scanty urine.

Carroll Dunham valued *lachesis* very highly, and used it "when constitu-

tional symptoms predominated over the local," along with throat symptoms of slight intensity, great prostration; slow, feeble pulse; cold, clammy sweat, and pain out of proportion to the local lesion; exudation worse on the left side; lividity and ulceration of mucous membrane, painful deglutition.

Arum triphyllum becomes of value when there are very acrid discharges from the mouth and nose, which excoriate and form large crusts about the orifices. Diphtheritic deposit excessive and mixed with more or less ulceration; also, much involvement of the glands and deeper tissues and adjacent skin.

In *arsenicum* we have a remedy which is not used enough in diphtheria, especially in those cases in which urine is scanty or suppressed; when partial or general dropsy is present, accompanied by great debility, pallid countenance, puffiness of the face and eyes; great anguish, extreme restlessness and fear of death; fetid breath, and viscid, foul discharge from the nostrils.

Rhus tox. is very often indicated by the well-known symptoms of that drug in connection with extensive swelling of the lymphatics and glandular tissue.

Phytolacca becomes useful when the cases simulate follicular tonsillitis, but with very fetid breath, and weakness unusual in that disease; deglutition almost impossible; drowsiness accompanies prostration; constant inclination to swallow; nausea, vomiting and diarrhoea. Of no value in malignant cases.

Cantharides is indicated when the throat looks as if it had been blistered; burning and dryness of the mouth, extending to throat and pharynx; constant desire to urinate, passing but few drops at a time.

Lycopodium may be used when the exudation is worse on the right side; brownish-red appearance of the fauces; widely dilated nostrils with each inspiration; "red sand" in the urine; worse from warm and better from cold drinks.

Hydrochloric acid has considerable reputation among all classes of practitioners. Hughes recommends it in "the lesser degrees of toxæmia." In general the symptomatic indications are the same as those calling for its use in typhoid fever.—*Medical Era*, August, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF LOCOMOTOR ATAXIA.—Ogle, of Indianapolis, recommends official methods, diet, rest, baths, electricity and massage in the treatment of tabes. He believes that the chief value of drugs is in the moral influence they exert and in meeting the various symptoms as they arise. Despite the fact that syphilis is a potent factor in the etiology of the disease, mercury and potassium iodide have but little value. In the treatment of the distressing pains we must resort to morphia or, better, antipyrin, the initial dose not to exceed 3 to 5 grains.

The dominant school uses arsenic in full doses, argentum nit. in quarter-grain doses, and *corrosive sublimate* in $\frac{1}{30}$ -grain doses q. i. d. Of our own remedies, *argentum nitricum* is now employed extensively by both schools. Osler recommends the drug, while Wood, Fitz and others discard it as of no value whatever. Goodno recommends its administration regularly in all cases where the indications do not point to some other drugs.

Belladonna is spoken of very favorably in the beginning of the disease,

especially for the lightning-like pains. *Gelsemium* is a remedy for some of the incipient signs, such as myalgic pains, loss of muscular power, strabismus, ptosis, diplopia, etc. *Alumina* is a drug which has the ptosis and diplopia characteristic of *gelsemium*, but in *alumina* the patient experiences more difficulty walking in the dark, and the soles of the feet feel cushioned; constipation and swaying of the body when the eyes are closed are also characteristic.

Dr. Wood says: "The effect of *ergot* in producing a tabetic affection justifies its use by those who believe in the ancient Hippocratic fantasy of *similia similibus curentur*." He claims to have used it in both the large and small dose without the slightest good effect. *Ergot* is employed, however, more by the older school than by the new, despite the evident homœopathicity.

Zincum presents a splendid homœopathic picture of ataxia, and is especially indicated in the early stages, when the pains are severe; while phosphorus, *nux vomica*, picric acid, *rhus tox.*, stramonium and sulphur may be useful.—*Medical Era*, August, 1900.

F. Mortimer Lawrence, M.D.

THE THERAPEUTICS OF PLEURISY.—Gatchell offers the following suggestions as to remedies:

Aconite.—To be of service, aconite must be given early. Its place is in the treatment of acute, uncomplicated pleurisy. Indications: Acute pleurisy, coming on with chill, followed by fever; thirst; quick and rapid pulse; skin hot and dry; rapid respiration; great nervous restlessness; stitching pains in the chest; dry cough.

Bryonia.—This is the leading remedy for plastic pleurisy; it is no longer of use after serous effusion has begun. Indications: Plastic pleurisy, with acute, stitching pains, greatly aggravated by breathing or the slightest motion; respirations short and rapid. Also, for the "dry" pleurisies accompanying pneumonia and phthisis.

Cantharis.—This is the most efficient remedy, following bryonia, when there is serous effusion or sero-fibrinous exudation. Sensation of heat and burning in the chest; characteristic urinary symptoms.

Apis.—For the stage of effusion, to promote reabsorption, especially when the effusion is of recent origin; also, in pleurisy following scarlatina. Absence of thirst; dark and scanty urine; œdema of the chest-wall; severe, burning pain in a circumscribed spot.

Colchicine.—Acute, general pleurisy, in rheumatic or gouty subjects. A peculiarity of the condition calling for this medicine is often: Aversion to the smell of food, which causes nausea and loathing.

Arsenic.—In the later period of the stage of effusion, which has failed to yield to other remedies. There is great dyspnœa, with but little pain; much prostration, the patient being weak and cachectic; cyanosis; restless anxiety.

Hepar-sulph.—Persistent plastic pleurisy. Great sensitiveness to the open air; moist skin; the patient easily perspires.

Rhus tox.—Acute attack coming on after exposure to cold and damp; after a wetting while heated and perspiring. Muscular pains in various parts; pains in the extremities; disposition to change the positions of the parts which is followed by relief.

Sulphur.—Plastic exudation, slow to disappear. Also, in cases of serous effusion, coming on insidiously and lingering. Great need of fresh air; feet and head hot; hands and feet burn; palpitation; atonic dyspepsia.

Kali carb.—Dry pleurisy complicating phthisis.

Mercurius corr.—Pleurisy complicating Bright's.

Phosphorus.—Pleuro-pneumonia.

Iodine.—In "scrofulous" subjects it replaces bryonia.—*Medical Era*, August, 1900.

F. Mortimer Lawrence, M.D.

SOME UNUSUAL SYMPTOMS IN A CASE OF MERCURIAL POISONING.—J. K. Mitchell records an interesting case with rather unusual symptoms. The patient, a man of German parentage, aged 36, and by occupation a watch-case engraver, was admitted to hospital with the following history: In October, 1896, the patient, suspecting he had pediculosis, used a vigorous inunction of mercurial ointment, two ounces of which were rubbed in by him. The next day, not satisfied with this, he rubbed in two ounces more. Within twenty four hours he was suffering from violent intestinal pain and furious diarrhoea, followed by vomiting, which continued for some days. In the course of the following five weeks he lost about fifty pounds in weight. Two weeks after the mercurial inunction he began to notice a numbness in the hands and feet, and this was soon followed by violent pains in the forearms and lower limbs. The pains were of shooting, stabbing and lightning-like character, with only the shortest intervals between. For several weeks (the patient says) he was scarcely without pain, and owing to the severity of these symptoms he entered the hospital. There was at no time any affection of the mouth (stomatitis) or of the gums. About three weeks after the inunction there was noticed some weakness of the hands, and very soon afterwards of the lower parts of the legs. This increased until there was complete paralysis of the hands and feet, with foot-drop and wrist-drop. This condition had lasted for three months, when the patient was admitted to the hospital. The thumb was much wasted, and could not be opposed to the fingers; the grasp was exceedingly feeble, and the forearm muscles were also wasted. There was slight tenderness of the nerves of the forearm, but not extending above the elbow. A similar condition was present in the legs. The foot could not be flexed at all; the leg muscles as far as the knee also shared in the atrophy, and the patient was quite unable to stand up. There was no history of any other infection or toxæmia to be obtained. The patient was a man of excellent character and habits, never given to constant or excessive use of alcohol, or to any other form of undue indulgence. His hair was falling rapidly when admitted, and he lost a good deal of it. At the same time there developed a mark like a brownish stain on the forehead, running diagonally from the middle of one temple to the upper part of the other, and also involving the skin of the eyebrows. It was very conspicuous on his fair skin. His improvement was very slow but quite constant under the treatment adopted, namely, daily massage, faradization of the wasted muscles, and later, alternating applications of hot and cold water to the extremities. He recovered completely, except for a slight weakness in the anterior tibial muscles. The interest of the case lies in the mode of infection, in the absence of the classical stomatitis and saliva-

tion of mercurial poisoning, and in the completeness of his recovery from the toxic neuritis. The pigmentation was also an unusual feature. (Pigmentation is noted in poisoning by other metals, especially arsenic.)—*Journal of Nervous and Mental Diseases*.—*Pa. Coast Journ. of Hom.*, Sept., 1900.

F. Mortimer Lawrence, M.D.

THE ACTIVE PRINCIPLES OF ARNICA, AND ITS MEDICINAL USES.—Douglass, of Baltimore, states that the ingredient long supposed to be of most consequence is *arnicine*, $C_{20}H_{30}O_4$, a bitter principle which is insoluble in water, but freely soluble in alcohol and ether, forming amorphous masses of a golden yellow color; or else the ethereal oil, which is also insoluble in water. For a variety of reasons, it is now probable that neither arnicine nor the oil, but "trimethylamine," is the really useful ingredient of arnica. Trimethylamine, C_3H_9N , is a clear, colorless fluid, which boils at a very low temperature, and then emits a fishy smell. It is quite freely soluble in water, in alcohol, and in ether, and its vapor is absorbed by water with great avidity. It has a strong alkaline reaction, and readily ignites, on the application of flame, even when diluted with an equal quantity of water.

The physiological action of trimethylamine, or of concentrated aqueous solutions of arnica, which contain trimethylamine, without arnicine, is as follows: Placed in simple contact with the skin, neither of these excite irritation, but if either of them be rubbed in for some time with flannel, the surface will become reddened. Like ammonia, they dissolve the little plugs of fat at the orifices of the sebaceous ducts. Applied to the mucous membrane, they act in a stimulant and caustic manner; pure trimethylamine is a decided caustic to mucous membranes. Taken internally, in large doses, it greatly reduces both the frequency and the force of the pulse, and causes a burning in the throat and stomach, but no sweating, no diuresis, no colic, and no diarrhœa. A drop of pure trimethylamine placed upon the lip produces burning and a flow of saliva; the mucous membrane is first reddened, and then the epithelium is cast off, leaving a slight sore.

The statements concerning the actions, both physiological and therapeutic, of trimethylamine, have been very various, as have been those respecting arnica itself. Bucheim, for example, regarded it as a substance of little power; but the recent experiments of Dujardin Beaumetz—one of the highest authorities upon the action of drugs—seem to render it clear that trimethylamine has a very definite physiological action, and that among other things it diminishes the excretion of urea. The external effect of arnica involves important questions, for while it is known that many persons have found it excellent application for bruises and for wounds, other observers have complained that it produces either an actual erysipelas or a peculiar violet-colored eruption, attended by great heat and pain.

For internal bruises, arnica is a most excellent remedy, neutralizing the ill effects of blows, falls and other mechanical injuries. Ecchymoses are rapidly dispersed by it, provided the medicine be administered shortly after the injury has been sustained. In cases of concussion and shock, resulting from railway accidents, it is also very serviceable. When used after amputations, arnica certainly has the power of uniting the surfaces very rapidly.—*Am. Med. Monthly*, Sept., 1900.

F. Mortimer Lawrence, M.D.

THE HAHNEMANNIAN MONTHLY.

DECEMBER, 1900.

IS VALVULAR DISEASE OF THE HEART TRANSMISSIBLE FROM PARENTS TO OFFSPRING ?

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the American Institute of Homœopathy, Washington, D. C., June 20, 1900.)

THE question that serves as the caption of my paper has confronted me so frequently that I am impelled to submit the problem of the correct answer to you for consideration and discussion.

When you discover numerous cases of valvular disease of the heart in the same family your mind naturally seeks for a cause that will legitimately explain the obvious fact. Practically, we are prone to underestimate the factor of hereditary transmission, and ascribe the accidents of disease to conditions and maladies prevailing in the present, and, apparently, therefore perfectly explicable to our mental eye, rather than to go back into the past, seeking for skeletons of disease, whose form and nature we must necessarily assume to have been of a certain kind pathologically in order to correctly explain the case in hand.

Nowadays a physician of an investigating spirit is more or less agnostic regarding the cut-and-dried diagnoses that are given him so readily when he attempts to ascertain the health-record of progenitors. This skepticism is most natural. We all know, or those of us at least who attempt an understanding of our cases with a reasonable degree of accuracy, how difficult

are the problems in diagnosis that confront us now in the living present. We frequently wait a long time before being sure of our ground. In certain obscure cases, the post-mortem revelations only tell the true tale, and, more frequently still, open our eyes to the fact that many heretofore undiscovered factors of disease have determined the death of the patient, and not the discovered facts that led to our diagnosis. If we in modern times are so little accurate in diagnosis, with all our effort and increased facilities, how shadowy must have been the condition of affairs, diagnostically, a generation or two, nay, even a decade or two, back in the past! How can we assume that the diagnoses then made were correct? If we assume that the diagnoses were correct, we may be building our conclusions on a foundation of shifting sand. If we assume that the diagnoses of diseases of a number of decades ago were probably incorrect, we are compelled to erect an hypothesis that we cannot prove has sufficient justification for its existence. Yet between this Scylla and Charybdis is the natural position of the question at issue, the transmissibility of acquired cardiac lesions, especially as based upon the reliability of past and present diagnoses. In this tumultuous sea of probabilities I plunge, and I may not reach the shore safely on either side of the vexed waves. I have the hope that some kindly rock will at least give me footing until the greater development of the science of medicine, in the near future, decides with more accuracy the status of a problem that, to my mind, rests on the uncertain foundation of the doctrine of probability.

I am fully aware, as you doubtless are, in approaching a problem such as I have broached in this paper, that the conclusions arrived at must necessarily be tentative. I know fully that I am trending on the boundaries of sciences collateral to medicine, and that it may be impossible to settle the question of the hereditary transmissibility of cardiac lesions from a purely medical standpoint. The biologist will probably make his nose decidedly *retroussé*, even to the forty-five degree angle, when he finds that I am even trying to talk about the subject of transmissibility, and I shall with equal probability have some Darwinian advocate thank me for trying to show how lesions can be transmitted (which I shall hardly try to do); and another one of the same ilk, but of slightly different order and genus, may

think that I am of the class that "rush in where angels fear to tread," to try to draw any conclusions from such limited data as must be at my command, and this latter individual is nearer the truth than he wots of. Still, the question is forever fronting me, and I must have it out for an airing, even should I learn nothing new from the discussion. I shall at least know that there are others who feel that this question is one that cannot yet be definitely settled. How vital, though, for the future of some lives, would the final settlement of this question be? How many "cardiacs" would marry and deliberately run the risk of transmitting their disability to their offspring if we could positively say that their own malady's mantle would fall upon the shoulders of their little ones? There is certainly a pregnant problem here. Its final solution would make for joy or sorrow either way; yet it is better to know, if possible, than to grope blindly in the dark. Let me present you a few family groups of which I have personal knowledge:

Group 1. Father and mother and two adult sons. The father and mother give no definite history of rheumatism. One of the sons, whom I saw a year or more after an attack of rheumatism (with a pneumonic complication), may have acquired his lesion during his attack of joint-inflammation. All the members of this family have valvular lesions. The father has decided cardiac symptoms, the mother few and occasional ones, and the son (the one who did not have rheumatism), symptoms only after severe exertion. A cousin died suddenly of heart disease, the mother of whom has an exceedingly irritable heart, but no discoverable valvular lesion.

Group 2. Mother and three daughters. Father is supposed to have died of uræmia. The mother had marked valvular disease, and passed away, under my care, from the combined effects of dilatation and an enormous aortic aneurism. All three daughters have valvular disease, two of whom show symptoms. There is no history of rheumatism in the family, but the symptomless case in one of the daughters had an attack of scarlet fever.

Group 3. Grandmother, three grown daughters (two married) and four grandchildren. The father died of cardiac disease. I have only examined one of the married women. She has a valvular defect. The four grandchildren all have valvular

lesions. (Two have recently died of phthisis.) The grandmother recently acquired an aortic lesion (she had prior to that time a compensated mitral lesion), secondary to rheumatism, while under my care.

Group 4. Father, mother and seven children. The father has a Bright's heart, the mother a mitral regurgitant lesion, latent, so far as symptoms are concerned, for at least ten years. I delivered her of two of her children. The mitral lesion gave no trouble at that time, but latterly compensation has begun to fail. The eldest child, a girl of twenty, has no lesion, neither has the seventeen months' old boy. The second oldest boy has an irritable heart, and all the rest have lesions. There is a history of rheumatism on the maternal side; but the mother herself never had an acute attack, nor had the father. Three of the children had scarlatina under my care, and I discovered the lesions while trying "to look out for them," if you will pardon the bull. What I mean is, that, fearing possible endocardial complications, I examined their hearts, and found ample evidence of pre-existing disease.

Group 5. Father, mother, six children, three boys and three girls. I have examined only the three latter. The father died of cardiac dropsy. All the boys have valvular disease, worst in the eldest.

Group 6. Grandmother, six adult children and two grandchildren. The grandmother has a dilated heart, two sons have normal hearts. Two of the daughters I have not examined, but of the remaining two one has an aortic aneurism and the other aortic stenosis and regurgitation. Both children of the latter have decided valvular lesions. The family are apparently decidedly lithemic.

Group 7. Father, mother and three children. The father has an acquired lesion, the origin of which is unknown. The three children have lesions. The father of the mother has a lesion.

Group 8. Father, mother and one child. Father free, but mother and child have lesions.

Group 9. Father, mother and four adult children. Mother free; father has a lesion, as also two of his sons. The others I have not examined. A daughter of one of the sons has a mitral regurgitation. The grandfather has rheumatism.

Group 10. Father, mother and two children. Father has no lesion; mother has; the son is free, but the daughter, grown and married, has. The daughter of the latter has a lesion. The family are gouty.

Group 11. Father, mother, daughter. Father has mitral regurgitation, the mother a pulmonary lesion and marked arteriosclerosis and multiple small arterial aneurisms in many of the easily visible vessels at the early age of forty-two, with no discoverable Bright's. (Since this paper has been written the patient has apparently developed acromegaly.) The daughter, aged twenty-two, has stiff arteries already and aortic and mitral disease. The father of the father had rheumatism, the mother of the mother aneurism and early arterial sclerosis.

I could go on giving you family groups almost *ad libitum*; but sufficient variety has been given to furnish food for thought. These groups of cases would certainly cause one to at least suspect the possibility of direct transmissibility of lesions of the valves of the heart. I use the word "suspect" advisedly, for I well know the almost utter impossibility of proving the truth of the family health records, or of being at all certain of the correctness of the limited data concerning the individual health histories of the several members of these groups prior to their coming under my observation.

Right here I want to say that I fully appreciate the fact that valvular disease of the heart is a very common affection, and that it may not be wise to lay undue stress on the point that these cases apparently occurred as the result of a family trend. It is barely possible, if we took the same number of persons not related by blood ties, and examined them, that an equal number of cases of valvular disease of the heart might be discovered; but, while possible, this is not probable. Remember, too, I am assuming nothing as proven. It is barely possible, too, that I, devoting, as I do, considerable attention to the heart, may draw conclusions from the number of cases I see as to the general prevalence of valvular affections that are not fully warranted by the wider experience of a greater number of observers. Still, admitting that of necessity I would see a few more heart cases than most general practitioners, it does not necessarily follow that my conclusions as to the very general prevalence of valve defects is incorrect, for the reason that in

all the cases I have so briefly outlined in this paper I was in attendance upon the families as a general practitioner and not as a heart specialist.

I fancy I hear some one say: "Well, admit that you have found these valvular lesions in such groupings as to force you to question yourself concerning the probability of hereditary transmission, you certainly cannot think you are dealing with anything more than a series of coincidences? Reason is opposed to any other assumption. How can an acquired lesion be transmitted? You would not expect to have a child minus a leg or an arm because a railroad train cut off the father's leg, would you?" I have only to say that the idea of coincidence is a very good one, but fear that the coincidences are so numerous that they suggest the possibility of being dangerously near facts. While I do know that a one-legged parent does not as a general rule beget a one-legged child, I also know that the most minute personal characteristics are transmitted. I know that a silken skin can be transmitted for generations, as can also a coarse-grained epidermis.

I also know that other anatomical peculiarities are passed down from generation to generation. If anatomical details personal to a family may be transmitted, why may not anatomy, altered by disease, be transmitted? Physical peculiarities are; why not anatomical? There ought to be no great difficulty in believing in at least the possibility of hereditary transmissibility of anatomical defects. Think of carcinoma and its appearance late in the life of a descendant. Think of Friedreich's hereditary ataxia. Think of insanity, diabetes, etc. Surely these diseases were at one time acquired. They did not exist in that family line forever. If there can be no anatomical or physiological transmissibility in these maladies, what can be transmitted? We would hardly like to place it on the ground of some sort of mysterious psychological photography, the negative of which has been developing, under the influence of an unknown alchemy, in some dark room of the individual's cycle of life. You may say that these cases of transmission are due to cell-impression, *i.e.*, that the ultimate elements of the individual had certain potentialities and proclivities. Yet, if this is admitted as an explanation, this very cell-impression must include anatomical modifications of the cell, even if these modi-

fications are not discernible by the microscope. If it be argued that the power of receiving an impression by a cell is simply a function of that cell, I reply that that function must have a foundation for its being; and, further, that the function would ultimately alter the anatomy, or the function is dependent upon anatomical power.

We know very little yet about this question of heredity, and we must put on the air-brakes hard lest we wreck our train of thought against the rock of assumption. Besides, it is not necessary to assume, in discussing the possibility of transmission in a broad sense, that an acquired disease is directly transmitted. The offspring may simply be put in the way of acquiring the parent's malady. It must be remembered that the changes that occur in the valves of the heart as the result of an inflammatory process are modifications of what is essentially normal anatomical tissue, and these tissues are wrong, in a pathological sense, only because these tissues are not in the exquisite juxtaposition of perfect physiology and anatomy. The tissues are themselves practically normal; they are simply displaced, as it were. This idea, however, is not to be considered as necessarily an argument in favor of direct transmissibility, but rather as a check objection to a too sweeping assumption that anatomical details, practically normal in themselves but displaced by disease, are not transmissible from parent to offspring.

Some one will say "I can conceive of the possibility of a mother in whom some valve defect exists transmitting it, but I cannot see how an anatomical defect in a father can be handed down to his children." Why not? The mother, it is true, has most to do with the growth of the child, but the inseminating principle of the father must be potentially as dominant of the future child as the vegetative functions of the mother. In some mysterious way the male element must represent the entire man, his anatomical virtues, as well as faults, else ordinary every-day experience is controverted, and established facts of common occurrence are overthrown. We may not know the "how" of this, but we do know the fact.

Much of the haziness of the question would disappear if we could be sure of our premises. If we assume that the lesions supposed to have been transmitted result from an endocarditis,

and not from a simple developmental error of nature, we may be nearer a rational solution than we dream of. We can only wildly guess at the causes of developmental errors in the pre-natal heart; we can assume much, logically, concerning a disease actually acquired *in utero*. There is now no reasonable doubt that a fœtus may have an actual inflammation of the interior of the heart during its nine months' residence in its mother's womb. Yes, endocarditis does occur while the fœtus is still knocking at the door of conscious life. But what about the causes of endocarditis? How much do we actually know of the ætiology of the malady that narrows the orifices and distorts the valves of the blood-pump? Very little, indeed. The history of endocarditis must be rewritten, and that soon. We are only too well aware that it occurs in rheumatism, in scarlet fever, in pneumonia, in pleurisy, in pyæmia, in typhoid fever, in diphtheria, in syphilis, and in the minor exanthems. I know, too, that endocarditis occurs in diseases and conditions in which the text-books deny that endocarditis takes place. I am certain that in some cases an inflammation of the lining of the heart ensues in so stealthy a manner as to give rise to no symptoms that suggest the possibility of an enemy attacking the citadel of life, the heart. I am sure that the classically described rheumatism of the text-books has a thousand sneaking understudies that never have an opportunity to appear upon the stage of disease as a typical malady, the programme of which is so elaborately given in our learned books, but, if they appear at all, are masked and seldom recognizable. I am satisfied that the blood state that induces an attack of rheumatic fever in many individuals is a latent, relatively symptomless condition, that may or may not be fired into a flame of symptoms by the torch of an exciting cause. In other words, many people have rheumatism, or the essentials of it, and do not know it. This point is equally true of the disorders closely allied to rheumatism, as the so-called muscular rheumatism, lithæmia, gout, etc. What I am trying to get at is that endocarditis, exclusive of the cases caused by strain, *is produced by morbid material circulating in the blood*. The element or elements that incite endocardial inflammation is carried into the interior of the heart by the blood stream, and those morbid materials that have special affinities for the character of tissues that are

found within the heart and near valves may attack them and cripple the heart. Both latent and acquired blood states, not necessarily exciting acute or even recognizable symptoms, it seems to me quite logical to assume, in view of the great prevalence of valvular maladies, are quite capable of giving rise to endocarditis, both recognizable and unrecognized, clinically, at the time of their occurrence. If the mother at the time of conception, or afterwards during the period of gestation, has a blood stream contaminated by some agent capable of inflaming the endocardium, either latent or declared, there seems no good reason why the blood stream sent to the fœtus should not give rise to a similar blood state in the inhabitant of the womb. It is true that the right heart is said to be most affected in intra-uterine endocarditis, but it must be remembered that the blood stream from mother to fœtus nourishing the fœtal tissues is *supersaturated* with the same poison that directly attacks the valves of the right heart, and, it seems to me, ought to also affect the structures in the almost functionless left ventricle by virtue of the supersaturation and the special affinity the poison has for the character of structure composing the valves, even although those valves are not active physiologically. Indeed, the active right ventricle ought theoretically, by its increased activity, to escape with relatively less damage than the relatively-resting left ventricle. Given a tissue vulnerability to a certain poison, and it need not reach the heart by a big blood pipe, but by several small or a myriad of tiny ones, and yet the havoc be produced. Another mode of valve mischief is possible. The blood of the new-born child, surcharged with elements capable of causing inflammation of the heart's lining, sets up its havoc, and this womb-acquired blood condition can only be overcome when the *infant makes its own blood*, that is, when the blood elements formed by an independent existence are accumulated and dominant enough to overthrow that obtained from the mother fountain.

The father cannot of course dominate the embryo nutritively to the same extent as the mother, but he can furnish the elements that will develop the necessary agents in the fœtus itself while it is growing *in utero*. Perhaps the father more readily than the mother can cause the transmission of acquired valvular defects, while the mother, through sending poisonous

material to the womb in the blood-stream, the factors that determine an attack of prenatal endocarditis.

It does not negative the possible value of these assumptions because parents having valvular defects do not always transmit their lesions. Clinical experience shows that in other transmissible diseases some members of a given family escape without lesions. Neither does this fact invalidate the possible value of our presumption of transmissibility. We all know that diseased blood-states have their ebb and flow, even in chronic conditions. If conception were to occur on the ebb tide of the blood contamination, the possibility of escape can be readily imagined.

It might be objected that the probability of the correctness of this assumption is also negated by the fact that the same lesion possessed by the parent or parents is not transmitted. A mother with mitral regurgitation does not always transmit mitral regurgitation. Sometimes a complex of lesions exists. If a foetal endocarditis has occurred it would, of course, follow its own laws, and attack the valves and openings as it pleased. If it were an anatomical transmission, the same structures, if not the same valve, are affected. We could not, I think, expect a transmitted lesion to be of photographic similarity. We never see photographic transmissions even in Nature's happiest moods. While there is a sameness, there is also a distinct difference in all her work. Besides, it must be taken into consideration that there is a tremendous trend in nature to preserve the normal type, a mysterious motive-power ever fighting against innovations against the type that nature has set as the normal. The influence of an unaffected parent also tends to prevent not only the transmission of the lesion, but, also, failing that prevention, the transmission of the exact lesion to the offspring.

It would be too narrow a view, I opine, to declare, if cardiac valvular lesions are handed down from parents to offspring, that the evidence of transmission must be evident at the time of birth. Such a position as this would be simply begging the question. While it is possible, from a theoretical standpoint, that the actual lesion that has been transmitted may be found at birth, it does not follow that all lesions that are transmitted will disclose themselves at that time. The lesion must be cer-

tain in extent and disposition acoustically before it can give rise to the signs by which the defect may be recognized. But, aside from this, the infant may develop its endocarditis from the blood impulse received from the parent, at almost any period after its birth, and yet be essentially and practically a transmitted defect. Such lesions are most likely to be brought to the fore by some strain upon the heart induced by the actual work of development. In other words, a lesion might be considered to have been of hereditary origin in which no disease capable of giving rise to the valve mischief had occurred, that is, if we were sure that we know all diseases and blood states that might produce endocarditis.

Of course, in my paper, I have endeavored to conceive of an anatomical basis for the assumptions I am making concerning transmissibility. I recognize the fact that back of all anatomic and physiologic phenomena there is a moving force about which we know little and can guess less. I mean the great physice force, that may possibly do as it pleases with all created beings. We are beginning to get faint glimmerings of the fact that the ultimate anatomical cell may have more functions than we can discover by microscope, or even dream of. Certain it is that the suspicion has often occurred to thinking men that, to a limited extent, at least, one cell may temporarily take upon itself the function of a dead or wounded fellow. The mystery of how life was sustained at all, after we view certain subjects with gross lesions on the post-mortem table, is perhaps inexplicable upon any other basis. Who has not seen life sustained for a comparatively lengthy period when the investigating knife showed scarcely enough anatomical basis to perform physiologic function over a single night, and yet these patients had existed miraculously under our very eyes. Verily, it is unsafe to draw any positive conclusions in this stage of the development of medical science. But, we know so little of this mysterious life force that, as it were, shines through created man, as a sunbeam through the trees, that we are perforce tempted to explain phenomena such as we are considering upon a basis that we at present assume is tenable. The near future may betray much of this physice life to us, and, when known, if it be knowable at all by finite mind, will explain and make simple much that is now mysterious.

I trust I may be pardoned by the biologists and Darwinians when I confess to an extremely limited knowledge of the science that is supposed to tell us all about transmissibility. I have not had the time to study the subject from their standpoint in the preparation of this paper. I confess, too, that I have in my possession no available literature from a medical standpoint that could throw any definite light in solving the vexed question propounded. I have, therefore, simply presented the thoughts that naturally occurred to me, when I have endeavored to solve the question for my own satisfaction, without at the time considering the possibility that I should ever unveil them to the medical public. I have confidence that this offspring of my inner consciousness will, in its nascent state, be kindly treated by you. This paper must be regarded as simply a contribution to the subject of transmissibility.

The conclusions I have drawn from my study of the subject of possible transmission may be thus briefly stated:

1. It is probable that the anatomical defects of an acquired valvular lesion can be transmitted from parents to offspring.

2. It is more than probable that the greater number of cases of what may be considered congenital valvular defects arise from an intra-uterine endocarditis.

3. That lesions are not always transmitted, even when serious, because (*a*) the disease that gave rise to the lesion has passed away and left only its monument in the parent; (*b*) because of nature's eternal tendency to preserve her normal types; (*c*) because of the possible nullifying influence of an unaffected parent; (*d*) because of the temporary or permanent absence of an active blood state in either or both parents capable of setting up an endocarditis.

4. That we cannot be certain that organic valvular disease will or will not be transmitted.

5. That a mother suffering from an acute or sub-acute blood state capable of inducing an endocarditis is liable to pass that blood state to offspring and induce a valve incapability if conception occurs at the time the blood state is active.

6. That clinically we cannot yet determine the exact amount of blood-contaminating element capable of inducing a lesion, and do not know all the blood states and conditions of blood capable of giving rise to pre-natal endocarditis.

7. That we cannot yet give a positive opinion as to the exact liability of transmission to cardiac cases contemplating matrimony. We can only state the degree of probability.

8. That a practical deduction from a consideration of all these factors is that investigators of the present and future should devote more time to the determination of blood states capable of inducing valvular lesions and their modification by therapeutic measures.

HAS HOMŒOPATHY RETROGRADED?

(Read at the Brooklyn Meeting of New York State Society, October 4, 1900.)

BY M. W. VAN DENBURG, M.D., MT. VERNON, N. Y.

I WISH to count myself among those who believe homœopathy has a mission in the world that no other school of the present can fulfill.

While we are not among the foremost in studying the causes of disease, we are not among the last in applying the discoveries of others in these lines. We are ever ready to accept new facts regarding environment, physiology, hygiene, chemistry and biology. We have competent workers in all the special branches of medicine, of which we need not be ashamed. But we differ from all other schools in having a scientific basis for the application of drugs to disease.

All other schools are without a clear, reasonable and comprehensive method of procedure, based on experimental data, and of logical and universal application.

The mission of homœopathy lies in propagating this truth; in keeping its application abreast the times; in modifying and readjusting facts observed in the past to discoveries made in the present, so that the whole shall blend in a harmonious unity.

No one will question the advancement of homœopathy in members, in standards of education, in schools and hospitals, in social standing and public estimation, in all that appertains to material, intellectual and social progress. Neither will any one question the advancement of homœopathy in the line of special features, such as mark the progress of medical practice

in other schools. How is it with us in that peculiar field in which we are unique—have we progressed or retrograded?

Not to progress is in fact to retrograde. The medical world advances from age to age; all things change; growth means change. Have we changed for the better, or for the worse, or stood still? The last two mean retrograde change.

Do we recognize that we have passed into new conditions, and do we fully realize what they are? The thoroughness with which we recognize this change, and the efficiency with which we meet it, will measure our fitness for the sphere we occupy.

What are these changed conditions?

In the first place, from having a narrow and scanty armamentarium of drug-provings and drug records, our *materia medica* has become so bulky that *not one man in a hundred uses one-fourth of the drugs set down in the books.*

We do not need to prove new drugs. We do need to have our facts as now given confirmed and strengthened, or set aside as non-essential.

A second new condition lies in the fact that the courage and ardor for drug-proving has died out.

The most important reason for this change is the modern fear of drugs. In Hahnemann's time, and for a generation later, the laity were accustomed to huge doses of crude drugs. They expected to be made sick by them, and did not fear such sickness. Now both the laity and the profession fear drug-sickness quite as much as, or even more than, natural diseases. On this account voluntary provers are scarce, and are growing scarcer every day.

The feeling that our *materia medica* is already too large to be usable hinders the profession from entering into new provings with the zest of former days. This of itself will always in the future prevent any general revival of drug-proving.

A third changed condition is the modern methods and means of investigation. Had we the old enthusiasm, born of environment, we might improve our drugs under these new conditions. We shall be forced to study our old facts in the light of these modern changes, and content ourselves with re-adjusting them on these new lines. The facts remain the same; the interpretation of them changes with changes in co-ordinate and cognate branches of knowledge.

A fourth changed condition lies in the extensive application of homœopathic materia medica by a vast body of practitioners.

In the hands of these ceaseless workers, under the stimulus of keen competition and better physiological, chemical and psychological knowledge, our materia medica is being sifted as never before. The wheat is being separated from the chaff. But the trouble is that each sifter is keeping his little pile of solid grain to himself, instead of all being collected in one great common storehouse. Such a treasury would be like the fabled cruse of oil, increased by the using. This is no figure of speech, but a cold fact, arising from our changed conditions, which we do not half appreciate.

No extensive nor comprehensive method has yet been put in practice for gathering up these solid grains of therapeutic experience.

Herein lies the real retrograde, if retrograde there be, in the homœopathy of to-day. To stand still is to retrograde. To move too slowly and fall behind the procession is almost as bad.

What we need, I repeat, is not proving, but improving what we have. And there is no test like the bedside test. He will be a new Hahnemann who shall guide these new forces into the path of an efficient garnering of the facts now scattered, lost and wasted.

We have advanced, but we are loitering now; resting on our laurels; waiting for something to turn up.

THE USE OF STIMULANTS IN TYPHOID FEVER.

BY J. E. BELVILLE, A.M., M.D., PHILADELPHIA.

(Read before the Wm. B. Van Lennep Clinical Club, Philadelphia.)

I do not propose to enter into a lengthy and scientific discussion of the use of stimulants in general, and their use in typhoid fever in particular, but simply to give the results of my own personal experience of their use in this connection. In an extended experience in typhoid fever, covering a period of fourteen years, and in a locality where the disease was endemic, with fre-

quently recurring epidemics, nothing has struck me more forcibly, in consultation and in private conversation with attending physicians, than the timid and erratic use of stimulants.

Prescribed frequently too late or too early in the disease, and when prescribed ordered in indefinite dose and with an indefinite purpose of fulfilling indefinite indications, I do not wonder that many seem skeptical as to their value, or that with many the counter-indications weigh too heavily in the balance.

I have seen cases *in articulo* where it was considered a sufficient dose of alcohol to order a teaspoonful of brandy to be added to a half-tumblerful of water, and of this dilution a teaspoonful every hour or two; and on the other hand, where, under similar indications, with œdema of the lung, it was considered a maximum dose to order a tablespoonful of brandy every two hours. Believing, as I do, that alcohol in these cases is a sheet-anchor, it did not seem to me that it would be a waste of time to ask your attention to, and invite free discussion of, this subject. Just here let me quote a sentence from Osler's Practice: "It would seem like hoisting the teetotalers with their own petard to attribute the high rates of mortality in the London Temperance Hospital, 15 to 16 per cent. during the last twenty years, to failure to employ alcohol." I insert this simply for those who seem to think that strychnia and other heart stimulants are of prime importance, whereas I believe them to be valuable adjuvants but secondary to alcohol.

However opinions may differ as to the food value of alcohol in health, results derived from its use in typhoid fever cannot be gainsaid. It is not simply a stimulant to the heart, it prevents rapid tissue waste, a marked difference in degree of emaciation being observed under the use and non-use of alcohol, its use decidedly retarding tissue waste.

As to indications: The heart will always give notice when to begin the use of stimulants. If, from the beginning of the attack, you have kept up, as you should, an intimate acquaintance with its condition, you will often order stimulants before the increased frequency of the pulse would lead you to do so. Whenever you find the first sound of the heart losing its distinctness, it is time to begin to stimulate your patient, no matter in what stage of the disease this may be. I have frequently heard the remark: "I never use stimulants until the latter part

of the third week." In alcoholics the indication for stimulants will come early, almost at the outset, and it is better to anticipate the indications, if you know your patient, than to wait too long for indications. I recall a case in a young man of vigorous constitution, with no organic lesion of the heart, but who had some years previously been a hard drinker. His temperature never exceeded 102° , and, in the early period of the attack was but $100\frac{1}{2}^{\circ}$, and yet his heart gave signs of distress before the end of the first week, compelling a resort to stimulants, which had to be given in full doses all through the attack. Another case resulted fatally from a secondary pneumonia in the fourth week, and I have always blamed myself for it in that, failing to recognize the very young patient as an alcoholic, to all intents and purposes, stimulation was delayed too long.

Old people, too, require early and free stimulation. Patients under thirty do not as a rule require stimulants, but they need to be as carefully watched for indications. It is the usual practice, I am aware, when in doubt, to withhold stimulants, but I believe the rule in whist to be the best one to follow: "when in doubt, take the trick." The most harm that you can do will be to produce a little temporary excitement, which will soon pass away.

The two most important factors in the equation, to work out the solution you desire, are quantity and quality. As to quantity: It is impossible to put any limit on the quantity that may be required in a given case. There is no maximum dose, to my mind. Enough is the maximum, and what is enough in one case may be pitifully insufficient in another. The quantity is to be determined by the effect produced. The only guide which it has been my rule to follow is the disappearance of the odor from the patient's breath. In a severe case in a man 56 years of age, complicated with pneumonia, where Cheyne-Stokes breathing was present on three successive nights, the patient received at times a tablespoonful of brandy every fifteen minutes for an hour, then every half-hour; this through the night; the same amount every hour or two during the day. This course was followed for three successive nights, the case then improved, the interval between the doses was gradually increased, guided by the heart's action, and the patient went on to complete recovery. The man owed his life, I think, to the

fearlessness of his daughter, a trained nurse, in giving the brandy with a free hand, as ordered, following simply the direction to repeat the dose as soon as the odor disappeared from the breath. When using such frequently repeated doses it will be necessary to call into requisition a fresh nose in order to follow the above indication, else you may overdose your patient. It might be proper to say right here that where stimulants have been so actively demanded, I have never seen them rejected by the stomach.

Brandy I believe to be the best form in which to administer alcohol. None but the best obtainable should be used. Ill-effects, I believe, are due to the employment of stimulants when not indicated, or to the use of inferior products. It should be given simply diluted with water. It has always seemed to me an abomination to administer brandy in milk.

It must not be supposed that, in this paper, I am advocating the indiscriminate use of alcohol. In many cases it will never be called for; but I do wish to enter a plea for its use when indicated, and its fearless use, pushing it to the point of saturation, if I may be allowed the expression; and that limit is shown by experience to be evidenced by the non-disappearance of the odor from the breath. I believe that this use has turned the balance many a time when it was tipping dangerously near the death-line.

THE CONSTITUTIONAL INDICATIONS FOR SILVER NITRATE.

BY A. W. WOODWARD, M.D., CHICAGO.

(Read before the Chicago Homœopathic Medical Society, Oct. 18, 1900.)

THERE are certain facts concerning the physiological action of silver nitrate, hitherto neglected, which seem to determine its individuality as a therapeutic agent.

Having in mind the pathogenesis of our remedies, we have failed to see their resemblance to disease in other ways. If the particular symptoms of a drug resemble the symptoms of disease, it is reasonable to conclude that another similarity exists which it is desirable to know.

Referring to the provings of nitrate of silver, in *Cyclopædia*

Drug Pathogenesis, Nos. 2, 3, 4 and 6 made one proving each. No. 5 made three provings. Observing only the beginning of each proving, and avoiding repetitions, they were as follows :

No. 2. Took 1x. trit. on retiring; it caused metallic taste, followed by dizziness before falling asleep; sleep was dreamful, with much tossing about, and frequent waking. Next morning he had three stools; no relish for food; limbs very weary; he was drowsy, chilly, and had frequent urination; later he had palpitation of heart.

No. 3. After taking same dose, had nausea and retching; he could not get to sleep for images and fancies hovering before him; dreamful half slumber; was called to stool sixteen times before morning; great debility, especially in lumbar region, even to exhaustion; dry cough, with tickling in larynx; copious diuresis.

No. 4. Took the same dose; it produced coppery taste, nausea and retching; bluish color of lips and mouth; spasms in stomach, waking her from sleep; bloody stools; restlessness; the night was full of dreams; fainting, nausea, with violent palpitation of heart; feeling in sacrum as if menstruation was coming on.

No. 5a. Took the same; it produced metallic taste and nausea, followed by chilliness and shuddering; later a peculiar stiffness of legs; giddiness and hoarseness; pains in liver; drawing in of loins, with prostration; fullness in chest, with sighing and increased micturition.

No. 5b. After taking 10 drops 2x, no gastric symptoms were recorded; confusion of head; images and fancies crowded upon his mind in sleep; dull headache all night; slumber full of dreams, with confusion of head; weariness of limbs; frequent and copious urination.

No. 5c. After taking 10 drops 6x, he had an unusual appetite; pressure in abdominal walls after eating; depression of spirits; throat raw and sore; slight turns of cough; mind meditative and brooding; drawing pains in shoulder; itching in various parts; yawning and chilliness; coitus was painful.

No. 6. After taking 2x on retiring, he had emission of flatus; sleep was restless; he spoke out loud in sleep; next morning much itching in various parts; sneezing, following night colic, and four calls to urinate before morning.

Tabulating in each report the first symptom produced, as each general or systemic function becomes involved, we have the following :

Prover.	First Symptom.	Second Symptom.	Third Symptom.	Fourth Symptom.	Fifth Symptom.	Sixth Symptom.
No. 2.....	Metallic taste.	Dizziness.	Dreams.	Restless and weary.	Frequent urine.	
No. 3.....	Nausea.	Images hovering round.	Fancies and dreams.	Debility.	Cough.	Frequent urine.
No. 4.....	Metallic taste, nausea.	Bluish lips.	Waked by dreams.	Trembling and restlessness.	Palpitation of heart.	Approaching menstruation.
No. 5a.....	Coppery taste.	Chilliness.	Stiff legs and trembling.	Hoarseness, sighing.	Increased urine.	
No. 5b.....	No symptom recorded.	Confusion of head.	Fancies and images.	Weariness.	Frequent urine.	
No. 5c.....	Craving appetite.	Pressure in abdominal walls.	Depression of spirits.	Slight cough, yawning.	Drawing pains in shoulders.	
No. 6.....	Much flatus.	Restlessness.	Spoke out loud in sleep.	Itching of skin.	Sneezing.	Four calls to urinate.

Analyzing this table, it appears that in 6 of the 7 provings the first symptom was from the digestive tract. The second symptom was from the skin or sensorium. The third symptom was from the mental functions. The fourth symptom was from the motor organs in 4 cases and from the respirato-circulatory in 2. The fifth symptom was from the genito-urinary organs in 3 cases and respiratory in 3. The sixth symptom was from the genito-urinary organs in 3 cases.

It is fair to presume there were some errors in observation which, corrected, would show greater uniformity in the later records. The same drug, being taken by different provers, would show a different sequence of constitutional effects if the individuality of the provers governed the course of its action. On the contrary, there appears to be a practical uniformity of systemic effects to the fourth function involved. This points to the individual power of the drug. Probably further provings will establish this, and show that spinal and genito-urinary derangements follow.

Assuming that the constitutional effects of silver nitrate are shown by a consecutive disturbance of the digestive, cutaneous and mental functions, the question rises: In what manner can this knowledge be made practically available in therapeutics?

In reply, let us consider for a moment what we have learned.

It is not the relation of this drug to pathological conditions with their peculiar symptoms, but its relation to the healthy organism.

By this knowledge we have found the limitations which surround silver nitrate as a remedy, viz. : It must in all cases be adapted to the patient first, the disease being of subordinate importance. For example, in gastro-enteric disorders it will be useful only in primary cases ; it can be of no use in secondary forms arising from irritation of the skin or other parts, because the drug begins its action at the stomach.

The second effect of this drug is upon the skin and cutaneous nerves, consequently it cannot be useful in primary skin diseases, or in secondary cases arising from any source other than the digestive organs and nutrition.

The third effect of this drug is upon the brain, hence its usefulness is confined to mental disorders, epilepsies, etc., which have been preceded and are attended by serious derangement of digestive organs and skin. In primary cases, or in secondaries arising from other causes, it will not avail.

Again, in the provings the symptoms develop one after another, subside, return again associated more or less together ; and at all stages of the proving, or in cases of poisoning, it will be seen that gastric, cutaneous and brain symptoms of one kind or another are always prominent. This means that in any pathological condition where this drug is required, besides the local affection, symptoms of the stomach, skin and brain will also appear, the special character of the symptoms from these parts being determined by the nature and location of the disease.

By this rule the indications for silver nitrate in gastro-enteric diseases are seen in the prominence of the cutaneous and brain symptoms attending the case.

In cutaneous diseases the concomitant gastric and brain symptoms serve to individualize the case.

In mental and cerebral disorders, the gastric and cutaneous symptoms, together with the history of the case, would determine the choice of this agent. In the many forms of puerperal fever, this remedy would be required when the leading concomitants are seen in the gastro-enteric, cutaneous, and brain symptoms attending.

This outline of the guiding indications for the use of silver nitrate may seem of little value without comparison with other remedies having similar constitutional effects. For example: Arsenic or zinc, like silver nitrate, disturb first the digestive organs, and second, the skin; then their roads diverge. Arsenic strikes the spinal centres, while zinc attacks the respiratory organs and heart. What significance have these facts, for example, in malignant scarlet fever? Let us suppose three cases are before us. The throat and skin symptoms are much alike and most urgent in each case. In the arsenic case they will be attended by extreme prostration or restlessness as the leading concomitant, while the zinc case will be attended by alarming symptoms of respiratory or cardiac failure, and the silver nitrate subject will exhibit brain symptoms of grave import.

To further illustrate my argument the following cases, already published, are presented as showing the specific indications for this remedy.

Cholera Infantum.—A bottle baby was taken with violent vomiting and diarrhœa at frequent intervals. In twelve hours his eyes were sunken, face cold and pinched and covered with cold perspiration. Arsenic was given without benefit. The next morning he was unconscious and on the verge of spasms; vomiting and diarrhœa had abated; no urine had been detected since midnight: temperature sub-normal; pulse 120. *R.* Silver nitrate. The first dose relieved the kidneys and restored consciousness in four hours. Recovery followed.

Diarrhœa.—Vomiting of greenish water and frequent stools of greenish yellow. Pupils dilated; he lies in a stupor most of the time; urine suppressed; emaciation. Argent nitr. cured. —DR. CARROLL DUNHAM, *Hoynes' Therapeutics*.

Dyspepsia.—H. M. has loss of appetite; sour eructations; flatulence in bowels; craving for sweets; much itching of scalp, also of nose; sleep restless; great mental irritability in morning; urine scalding with frequent urging. Argent. nitr. cured. —DR. L. M. KENYON, *Hoynes' Therapeutics*.

Chronic Hepatitis.—Mrs. P. H. has had an enlarged liver for several years. It is sore to pressure. Has also suffered with sick headaches of violent character at frequent intervals. Last year she grieved intensely over the loss of her only son. This led to profound melancholy and angina pectoris. Since then her chest seems too narrow; she cannot get a good breath; has many muscular pains, chiefly in legs; urine very scant and dark. *R.* Argent. nitr. 2d dilution caused at first greatly in-

creased headaches; afterward steady improvement.—DR. MOSSA, *Hoynes' Therapeutics*.

Erysipelas.—H. W. B. has been subject to dyspepsia for many years. Had anthrax two years ago. January 10th, after a severe attack of dyspepsia, he was taken with a violent chill followed by headache. The next day erysipelas had developed on left cheek; pains in head were increased; temperature 100°; pulse 90; bowels flatulent; urine dark and scant. Third day his left eye was closed; œdema and redness now extends to scalp; sleep is broken; mind wanders; talks in his sleep. Fourth day sopor; he is hard to waken; urine diminished to eight ounces in twenty-four hours; restlessness increasing. Other remedies having failed, argent. nitricum was given with immediate improvement. Urine was more copious in two hours. Convalescence ensued on this remedy alone.

Hypochondriasis.—A clergyman became melancholic about five years ago. He has had chronic enlargement of liver and hæmorrhoids about twelve years. When they bleed, his head is relieved. He has lost flesh from year to year; hates company and does not want to work. About two years ago he sought relief for insomnia and loss of memory. These conditions are attended by loss of appetite, constipation, constant chilliness, cold extremities, and trembling on slight exertion. Argent. nitr. 2x, 5 drops night and morning, cured.—DR. VON GRAUVOGL, *Text-Book Homœopathy*.

Epilepsy.—Steven Martin was taken with fits in his eighteenth year. His physician thought they originated from the stomach, which was habitually acid. Spasms occurred about once in three weeks. They would leave him with violent headache and pains in eyes. On their approach he had flashes behind the eyes with blindness, and a bewildered feeling with pulsations in brain. All these symptoms were relieved and spasms arrested by the use of silver nitrate in doses of 1½ grains three times a day. Three months after, his face had assumed the leaden color peculiar to the use of this drug.—DR. BADELEY, *Cyclopædia Drug Pathogenesis*.

Spermatorrhœa.—A young man had masturbated for two years. He had complained for a long time of constipation, loss of appetite and sleeplessness. Last summer his friends remarked that he was gloomy and irritable; his appearance was that of an imbecile; his conversation was childish and words disconnected; his hands were shaky and legs weak; had horrible dreams at night. After other remedies had failed, silver nitrate was given. In three weeks he was a new man.—DR. C. P. SEIP, *HAHNEMANNIAN MONTHLY*, July, 1875.

HÆMATURIA—ITS SOURCE AND CAUSE.

BY W. W. KNOWLTON, M.D., PHILADELPHIA.

(Read by invitation before the Oxford Medical Club of Philadelphia.)

I HAVE chosen this subject for your consideration this evening because there are few symptoms of the genito-urinary system so difficult to trace to the exact source and cause, and few which prove so alarming to the patient.

In order to treat hæmaturia scientifically and successfully it is first necessary to ascertain the source and cause of the hæmorrhage.

Most text-books lay down certain rules to be followed in determining from whence the blood comes. These rules are based, for the most part, on the color of the urine, upon the time at which the blood appears in the stream, and upon the shape of the clot.

I do not think that much reliance can be placed on the color of the urine. Every urine with a reddish or brownish tint is not bloody, since an excess of uric acid, or of bile-pigments, or the ingestion of certain drugs, will give the urine a color very similar to that produced by blood. Again, the rules laid down respecting the color are very faulty. For instance, some teach that the brighter and more arterial the color of the blood in the urine, the nearer the source of the bleeding is to the meatus.

This rule is defective, because in cases of severe injuries to the kidney and in many cases of renal cancer the blood is passed into the bladder so rapidly and in such quantities that it is almost as bright when it comes from the urethra as it is when it comes from a ruptured bladder or a villous growth. Another and still more defective rule respecting the color is that the darker and more diffused the blood, the more probable it is that it emanated from a renal source. This rule is almost worthless, as the color does not depend upon the distance the blood has to travel, but upon the action of the urine on the hæmoglobin of the blood. The blood will become dark whenever it remains for a time in contact with an acid urine. You

will also have dark-colored urine in cases of profuse hæmorrhage of the bladder accompanied by retention and clotting, or in cases of bladder hæmorrhage where there is atony of the bladder with more or less residual urine, as in enlarged prostate or a tight stricture. Again, in a few cases, although there may be no residual urine, the blood may leak from an abraded surface of the bladder so slowly that it becomes mixed with a large amount of healthy urine, and there is voided a smoky urine which some authorities would have us believe is always renal.

The rules laid down respecting the time at which the blood appears in the stream are much more reliable than those pertaining to the color. In this connection three rules are given: First, Blood appearing toward or at the end of clear urination denotes a vesical or prostatic origin. Second, Blood appearing at the beginning of micturition is indicative of a prostatic origin. Third, Blood issuing from the urethra between times of micturition denotes a bleeding from the anterior urethra. The first rule is a good one and one upon which you can rely, and is exemplified by a case which I saw with Dr. Woodward. The patient was a female, past sixty years of age, who gave the following history: About one year ago she commenced to pass blood in her urine; she consulted an "Old-School" physician, who told her that her kidneys were diseased and treated her accordingly. She continued under the care of this physician about nine months, gradually getting worse. Her friends, becoming alarmed, persuaded her to change doctors, which she did, calling in Dr. Woodward, who carefully studied her condition and told her that he thought the hæmorrhage was from the bladder. He prescribed the indicated remedy and treated the bladder. This relieved, to a certain extent, the tenesmus and pain which she had been suffering with for months, but had little or no effect upon the hæmorrhage. When I first saw her she was very weak and emaciated. She told me that she urinated very frequently and that there was a constant tenesmus. When she passed water there was much burning and considerable pain. She said that as a rule the urine was clear at first, that it became bloody toward the end, and that the last she voided was almost entirely blood. Dr. Woodward and I examined her bladder with an electric cystoscope, and the first

thing that we saw was a tumor, about the size of a hen's egg, located to the right of the median line on the lower posterior wall of the bladder.

Rule two will hold good in 99 per cent. of cases. The exception to this rule would be in case a vesical clot settled in the prostatic urethra, in which case the clot would be washed out with the first rush of urine. I have no comments to make respecting rule three except to say that while there may be occasional exceptions to it, they are so infrequent as to be of little moment.

We have considered the color of the urine and the time at which the blood appears in the stream; it now remains for us to consider the shape of the clots. There are two rules in this connection. First, long, thin, rounded clots, shaped like earthworms or goose-quills, are almost certain to indicate bleeding from the renal pelvis, for they are moulds of the ureters. We may have worm-like clots which are moulds of the urethra, but they are more apt to be short and thick, and are swept away with the first gush of urine.

The second rule is: Large irregular-shaped clots are usually derived from a bladder source. While a majority of large irregular-shaped clots are of vesical origin, yet there are many cases in which the blood is of renal origin which clots after it reaches the bladder; so that on the whole this rule is of little aid in determining the source of the hæmorrhage.

Since the introduction of the cystoscope our means of making a correct diagnosis as to the source, and often as to the cause, of the hæmorrhage is greatly facilitated. In cases of hæmaturia of uncertain origin the cystoscope will reveal any pathological or mechanical cause liable to produce hæmorrhage of the bladder, providing the hæmorrhage is not so profuse as to discolor the water before the cystoscope can be introduced and an examination made. If the hæmorrhage be renal, the cystoscope will show from which kidney the blood is coming.

Having determined the source from which the blood comes, our next duty is to determine the cause. If it is difficult to determine the source of a hæmaturia, it is still more difficult to determine the cause.

The causes of hæmaturia are numerous and varied. They may be traumatic, or they may be due to the ingestion of certain drugs and certain articles of diet, or to disease.

Hæmaturia resulting from a traumatism may occur from any portion of the genito-urinary system, and when due to direct violence is readily located by the history of the case, the site of the injury giving a strong hint as to the source of the hæmorrhage. Occasionally there is a case which at first appears to be purely traumatic, but subsequent developments show the existence of some organic disease. Hence a hæmaturia following upon a sudden muscular action or an apparently slight violence should be looked upon with suspicion, as there is probably some organic trouble, such as tuberculosis, nephritis or tumor, particularly carcinoma, behind it.

In referring to this, Fenwick says: "In patients over forty (an arbitrary age), with unsuspecting softish growth of the urinary tract, it is often a slight strain which appears to be the cause for the first attack of hæmorrhage." In four out of ten cases of renal carcinoma under Fenwick's observation, some slight violence induced the first hæmorrhage. In one-third of the cases of soft vesical growth the onset of hæmorrhage was due to some slight traumatism. He concludes from these and other observations that should a slight strain or decided extra exertion be immediately or almost immediately followed in an adult over forty by a smart attack of hæmorrhage, you may with reason suspect a friable pre-existing growth. In cases of traumatism involving the kidney the hæmaturia which may ensue from damage of the renal tissue varies in proportion to the severity of the laceration. When the cortex is slightly torn, there may be no blood at all appear in the urine, but as a rule, even in a slight laceration, there is more or less hæmorrhage. In cases where the kidney has been severely contused or greatly lacerated the hæmorrhage is often alarmingly profuse; but, as I remarked a moment ago, the history of the case will make the diagnosis easy, at least as to the source of the hæmorrhage.

Anatomically, the bladder is so located as to be fairly well protected from injury. But, despite this bony protection, it is not uncommon for it to receive an injury, either resulting in a contusion or a rupture. Contusion of the bladder without rupture is rare. Rupture of the bladder generally occurs when it is distended, or as the result of rough instrumentation. The rupture may be either intra-peritoneal or extra-peritoneal. In

case of a violent succussion of the body or a blow upon a full bladder, a laceration or rent may occur, extending through the entire thickness of the posterior wall, letting the contents of the viscus into the peritoneal cavity. In this case there may be a loss of power to urinate, and with it a constant tenesmus. The introduction of a catheter usually draws off a variable amount of blood and urine, but it may fail to remove anything. If the rent is large, the beak of the catheter may slip through into the peritoneal cavity and draw off a large amount of blood and urine. In extra-peritoneal rupture the bladder retains its expulsive power, and usually the hæmorrhage mixes freely with the urine and is quite persistent. In either intra- or extra-peritoneal rupture the diagnosis should be comparatively easy.

In what is termed traumatic hæmaturia there are a number of other conditions resulting, along with other symptoms, such as contusions of the perinæum from a fall, straddle a fence, or a kick upon the perinæum, or from rough instrumentation, or from various operations upon the urethra, such as internal urethrotomy. But in all these instances the cause and source of the hæmorrhage is so obvious that no further comment is necessary.

There are certain drugs credited with producing hæmaturia, cantharides and terebinthina being the chief offenders. Turpentine may occasion a hæmaturia by inhalation as well as by ingestion. Reginald Harrison records an instance in which the whole crew of a ship carrying a cargo of turpentine had suffered from hæmaturia, one sailor dying. Certain articles of diet are known to produce hæmaturia if indulged in too freely or by those who have a peculiar idiosyncrasy. There are several cases reported as having been caused by rhubarb. The gooseberry, the unripe apple and the strawberry are credited with the same powers. Dr. Harrison also reports a case resulting from eating asparagus. There are other vegetables and fruits which color the urine like blood, but there is insufficient evidence as to whether they actually cause bleeding.

In considering hæmaturia of disease, I will first allude to that occasioned during the course of acute infectious diseases.

In small-pox, hæmorrhage from the kidneys occurs in the hæmorrhagic variety, known to the older writers as black small-pox; and according to Dr. John McCombie, an eminent

English authority on small-pox, it occurs most frequently in those who have been vaccinated. In scarlet fever the hæmaturia is generally due to a nephritis. In typhus fever, nephritis may occur during the course of the disease, or there may be a cystitis during convalescence from retention of urine, either of which may cause hæmaturia. There is a severe type of malarial fever in which hæmorrhage occurs from the various mucous surfaces. Malarial hæmaturia occurs in epidemic form in certain districts. The renal symptoms may be the sole manifestations, or they may follow paroxysms of ague. Death often follows in these cases from suppression of urine. There are other infectious and general diseases in which hæmaturia may occur; but suffice it to say that it occurs only in those cases in which a nephritis or a cystitis supervenes, or where there are marked blood changes giving rise to general hæmorrhages.

The renal diseases liable to produce hæmaturia are acute and chronic Bright's, suppurative diseases of the kidney, tumors, stone, tuberculosis of the kidney, and syphilis.

In acute Bright's, blood may appear as an early and prominent symptom, or it may at no time be appreciable to the unaided eye. While, as a rule, the amount of blood lost is only sufficient to slightly discolor the urine, there is an occasional case where the hæmorrhage is sufficient to markedly increase the already existing anæmia. Where there is dropsy, albuminuria, casts, gastric symptoms, fever, backache, headache, and anæmia, little doubt will exist as to the source and cause of the hæmorrhage.

In chronic Bright's the hæmorrhage is, as a rule, insignificant, and produces a smoky-colored urine. There are a few instances of cases reported where there was a profuse hæmorrhage; but such cases are comparatively rare. The hæmorrhage in chronic Bright's is sometimes induced by the too rapid withdrawal of urine from an overdistended bladder, due to some obstructive disease, stricture, enlarged prostate, etc., and in these cases the hæmorrhage is of a serious character, often ending in death.

Hæmaturia in the suppurative diseases of the kidney is, as a rule, slight, and, compared with other symptoms, unimportant. I have mentioned it in this connection because it sometimes does occur, and not because it is of any diagnostic importance in these cases.

Syphilis is credited with producing renal hæmorrhage. Fenwick cites a case in which a gentleman, aged 40, had for nine weeks a very bright symptomless hæmaturia, so bright, in fact, that it was thought to be vesical. On turning down the bedclothes to prepare the patient for a cystoscopic examination, a tertiary syphilide was noticed on the thigh, and on introducing the cystoscope, the blood was seen issuing from the right ureter. Iodide of potash in five-grain doses was given three times a day, and in two weeks the bleeding had completely ceased.

In renal calculus the hæmorrhage is generally mechanical, due to irritation by the stone. The amount of blood passed is not large, and the hæmorrhage is often intermittent. The patient may go for days without noticing any blood, and then it may suddenly appear, especially after a car or carriage ride, or, in fact, any form of movement that tends to jar the body. Hæmaturia from stone always ceases or improves on rest, thus differing from that induced by tuberculosis or cancer.

In renal tuberculosis we frequently have hæmaturia, blood and pus appearing in small amounts in the urine, either coincidently with renal pain or very soon after. The stages of the disease are passed, as a rule, quickly, and the bladder is affected early, particularly if the disease starts in the pelvis of the kidney. When it starts in the cortex, as it often does, it has to break into the pelvis before it gives rise to the characteristic symptoms of the disease. The hæmorrhage varies also with the two positions, that is, whether the disease be pelvic or cortical. In the early stage of pelvic ulceration the bleeding is usually slight and intermittent; when, however, a cortical deposit sloughs out suddenly into the pelvis, there may be a profuse but transient hæmorrhage; but, on the whole, hæmaturia from tuberculosis of the kidney is seldom profuse.

Of all renal hæmorrhages, those which result from a growth are by far the most severe and alarming. The bleeding is profuse and spontaneous, and recurs upon the slightest provocation. It is very exhausting, and often ceases abruptly from a clot becoming impacted in the ureter. Long worm-like clots are often expelled either just before or just at the close of urination. The growth may be benign or malignant. Benign growths are rare as compared with malignant ones. Fibroma and adenoma are the

varieties of benign growths most frequently found. Of the malignant growths sarcomata are the most common, and, strange to say, are most frequently found in children. Hence, hæmaturia in a child under ten years of age strongly suggests malignant disease. The hæmorrhage in cancer of the kidney is profuse, intermittent and apparently causeless.

The differential diagnosis, so far as hæmaturia is concerned, between tuberculosis of the kidney, stone in the kidney and tumor of the kidney may be, in many cases, expressed by the words mild, moderate and profuse. That is, a mild, intermittent hæmaturia, increased by exercise and improved by rest, suggests tuberculosis, especially if there is a tubercular family history. Moderate intermittent hæmaturia, induced or increased by exercise and disappearing on rest, suggests stone; while a profuse intermittent apparently causeless hæmaturia, plus worm-like clots, suggests a tumor, probably cancer.

The diseases liable to cause vesical hæmorrhage are: cystitis, prostatic troubles, vesical growths, varices of the bladder, tubercular ulceration of the bladder and stone.

In uncomplicated cases of cystitis the hæmorrhage is slight and intimately mixed with the urine. The majority of cases of cystitis are complicated with some other trouble, such as stricture, enlarged prostate, stone, etc., of which I will speak in a few moments.

In prostatic troubles, particularly senile hypertrophy of the prostate, the hæmorrhage may be spontaneous and quite profuse; in fact, sufficient in the aged to cause no little uneasiness for the safety of the patient. Riding, a fall on the buttock, or a sudden congestion of a nephritic kidney, which co-exists in quite a percentage of these cases, are among the causes. The blood may escape pure and free from urine, staining the shirt or bed linen, and leading one to think that it originated from the anterior urethra, thus making an exception to the third rule relating to the time at which the blood appears in the urine. The rule I refer to is that blood issuing from the urethra between the times of micturition denotes a bleeding from the anterior urethra; the blood may appear at the commencement or at the end of the stream, or it may pass back into the bladder and mix with the urine. The history of the case and a rectal examination will guide you in making a diagnosis, but you

must always keep in mind carcinoma of the prostate. In carcinoma of the prostate the hæmorrhage is quite profuse, and there is nothing characteristic about the hæmaturia by which you can differentiate it from a simple senile hypertrophy, but there will be other symptoms that will help you out.

As in renal growths, vesical tumors may be benign or malignant. It would have greatly simplified the diagnosis between benign and malignant growths if the former were unknown past middle life, and the latter were never met with before 45; but unfortunately such is not the case. Youth does not carry immunity from malignancy.

Benign growths commence insidiously and last for years. While malignant growths may be insidious in their onset, they are much more rapid in their development, and are far more fatal. In vesical growths the character of the blood in the urine varies as to time, quantity and color. The blood may appear at intervals of a week or more, or it may occur each time the patient urinates. The color may vary from a coffee color to a bright red. The quantity passed varies according to the size, character and location of the growth. In non-malignant cases, where the tumor is hard, and situated so as not to be encroached upon by the bladder in its efforts to expel the last portion of urine, the amount of blood is small, and barely discolors the urine; while in other cases, especially if malignant, where the growth is soft and friable, and located, as most vesical tumors are, near the base of the bladder, every time the patient urinates, which is often in these cases, the bladder, when it shuts down, as it were, to expel the last few drops of urine, squeezes the growth, and the blood is forced from the tumor like water from a sponge, and as a result we have a frequent, terminal, bright-red, profuse hæmaturia.

Varicose veins of the bladder, or, as some writers term them, hæmorrhoids of the bladder, are comparatively rare. When seen it is generally in the aged, who have long been afflicted with stone in the bladder, stricture, hypertrophied prostate, or organic disease of the anus or rectum. The symptoms are frequency of urination, tenesmus, pain and hæmorrhage. In case of rupture of one or more of these varicose veins, the hæmorrhage is copious and alarming, and demands prompt interference.

It is hardly necessary to allude to the symptoms of stone in

the bladder, as they are so well known. In children and young adults they are especially marked; while in old men, with enlarged prostates, where there is considerable residual urine and a good-sized post-prostatic pouch, the classic symptoms of stone may be entirely wanting. The stone may lie in this pouch for weeks, and, aside from a slight feeling of weight and discomfort, no symptoms of stone will be manifest. The hæmaturia of a vesical stone is due to the friction of the stone, and is worse when there is a co-existing cystitis, which is rarely absent in these cases, and is markedly aggravated by motion. If, therefore, you have a vesical hæmorrhage depending upon exercise, you may suspect stone; but always remember that exercise has the same effect in producing or increasing hæmaturia in cases of villous growths, carcinoma or tubercular ulceration of the bladder. On the other hand, if hæmaturia persists in spite of rest, you may exclude stone. There is a marked similarity between the symptoms of stone in the bladder and those of tubercular ulceration. Tubercular ulceration of the bladder, in its early stages, mimics stone so closely that it is very easy to mistake the one for the other. I will try to picture a case of tubercular ulceration of the bladder showing this similarity. Take a young man between 18 and 25 years, possibly without a venereal history, but with a family history of tuberculosis. This young man may suddenly experience pain in the glands and mid-penis while urinating. He then notices increased frequency of urination in the day, and a little later his nights are disturbed by constant calls to urinate. These symptoms are followed in a variable time by the appearance of blood in the urine. The bleeding may be profuse and bright, due to a sloughing out of tubercular deposits; but as a rule the hæmorrhage is sparse; he only sees a few drops of blood follow the end of the stream. If you ask him whether the stream continues until he has emptied his bladder, he may say no, and tell you that it sometimes suddenly stops in the middle of the act, but will fail to further state that he stops it voluntarily because of the intense pain, thus leading you astray. Thus you see there is quite a similarity between tuberculosis of the bladder and vesical stone. There are, however, points of difference in the patient, in his symptoms, and in the urine. The family history; the age, the distressing irritability at night; the sudden

and apparently causeless hæmaturia, not increased by exercise and not checked by rest; the disappearance of the glands-pain after emptying the bladder; the very light, acid, puriform urine, all point to tuberculosis, and not to calculus. Later, all doubt will be dispelled by the epididymis becoming implicated, and the prostate having a shotty feel from the deposits of tubercles.

As I said before, since the advent of the cystoscope we are enabled to explore the bladder and locate a stone, or to see a varicose condition of the veins if present. It brings into view tubercular ulcerations of the bladder wall, shows us a tumor or tumors, and, in case of hæmaturia from the kidney, shows us from which kidney the blood is coming, and puts us on the right track to make an intelligent diagnosis.

THE LOCAL USE OF ARSENIC IN MALIGNANT ULCERATION.

BY GEORGE L. VAN DEURSEN, M.D., LOWELL, MASS.

(Read before the Massachusetts Homœopathic Medical Society, October 9, 1900.)

IN our present age of brilliant surgical work, where the skillful operators may be counted by the score, instead of marking here and there a solitary individual who has achieved distinction in this direction, we are many times inclined to call in the services of the knife in conditions where the proper medicinal treatment would give more permanent, if less immediate, results.

In malignant growths of the epithelial class—epitheliomas, carcinomas, etc.—where they come to us sufficiently early to permit of their complete excision, the operative treatment is generally advisable; but in that large number of cases where the patients consider their trouble as only a simple matter till ulceration is far advanced and the surrounding tissue deeply infiltrated by the growth, or in case of recurrence after removal, we must look to medicine rather than to surgical interference.

In the use of Arsenic in these conditions I have nothing to present which is either original or novel; you are all familiar with the general therapeutic action of the remedy and with its

specific action on the skin. My excuse for this paper is to recall the method of employment introduced and advocated by one of the most careful observers of our school (I refer to Dr. J. S. Mitchell, of Chicago), and to record several cases which have been successfully treated by that method. Dr. Mitchell is not the pioneer in the local use of arsenic, nor does he claim any such position, for the drug has been used in pastes and powders since the beginning of the practice of medicine. His only claim to originality is in "the use externally of homœopathic triturations of sufficient power to cause disintegrating effects, combined with continuous internal medication."

The relation existing between Arsenic and various forms of epithelial hyperplasia, malignant ulceration and tubercle formation has been understood and noted by writers of all schools of practice, but it has remained for the fathers of our own school to properly interpret this relationship and to apply the remedy according to the law of similars where properly indicated. Whether the continuous use of Arsenic will produce true cancer, as has been claimed by some eminent old-school authorities, is not essential, but the provings of the drug show unmistakably the tendency to ulceration and gangrenous sloughing, accompanied by the intense stabbing burning pains which characterize carcinomata and kindred growths. In addition to this intense action of the drug we have the milder manifestations seen in the waxy, parchment-like skin, so closely simulating the late cancerous cachexia and the dry, scaling, itching eruptions with which we are all familiar.

Allen, in his "Handbook of Materia Medica," says: "Arsenic is above all a tissue drug, ranking with phosphorus and antimony. An irritant poison . . . the skin is irritated, and violent itching and burning are followed by eruptions and finally ulceration. Glandular action is first excited, then diminished." In studying the symptomatology of the drug we find: "Skin white and pasty or dark and livid, dry and rough. Eruptions around the mouth, burning and painful, itching; worse from scratching. Red herpetic eruptions around the mouth. Ulcers on the face, with burning pain. Fleshy excrescences spring from ulcers; soon become gangrenous. Ulcers, with thin bloody pus coming from under thin scab. Indurations and tumors becoming ulcerative."

Farrington, in his wonderfully written "Clinical Materia Medica," tells us that "Arsenic alters the blood. It is useful in low types of disease when the blood changes are serious. The inflammations of this remedy are characterized by their intensity and by the tendency to the destruction of tissue. In these local inflammations of arsenic you will find burning, lancinating pains the characteristic sensations. It tends to produce induration or hardening of the skin, rendering it a valuable remedy where there is a thickening of the skin with copious scaling."

With such authorities before us, the homœopathic use of the drug in these cancerous conditions is readily understood. It is not necessary to go into any of the theories in regard to the cause of epithelial growths; the fact which does concern us is that there are certain new growths springing from embryonic tissue, developing to a certain point, then undergoing retrograde changes, instead of going on to full development. In the treatment of these growths many methods have had their advocates—the knife, chemical or actual cautery, pastes, ointments, internal and external medication.

In many cases of primary growths, where the affection is well localized, a clean incision, involving sufficient of the healthy tissue to preclude the probability of recurrence, may be effective; but even then the constitutional condition needs correction by proper medication. The actual cautery and the stronger caustics are extremely painful; they involve a large area of healthy tissue in connection with the growth, and their employment does not prevent recurrence. The caustic pastes are open to the same objections, and the irritation produced by them in many cases causes the growths to take on a new activity. Electricity in its various forms has been used to a greater or less extent, but its practical utility has not been fully demonstrated.

The method to which I wish to call your attention, and with which many of you are no doubt familiar, is the use of a homœopathic trituration of Arsenic, giving the 3x usually internally, and applying the 2x locally, three to six times a week, according to the conditions. It is advisable to cleanse the surface thoroughly with peroxide of hydrogen, then apply carbolized linseed oil freely over the raw surface and dust on the 2x trit.,

covering all ulcerating tissue. The carbolized oil is a preparation of one part pure carbolic acid in twenty parts linseed oil. It is recommended by Dr. Mitchell for cleansing and disinfecting purposes, and helps hold the powder in place. In places where an outside dressing is required, after dusting on the powder, cover with a layer of gauze moistened with carbolized oil, and over this a layer of absorbent cotton, held in place by adhesive straps. Dr. Mitchell speaks of the use of Hoang Nan, Chloride of chromium, and other remedies to assist the action of the arsenic in some cases, but in the following cases it was not necessary to call on any of these supplementary agents.

CASE I.—W. T.; expressman. When first seen was suffering from an epithelioma of the right side of the lower lip. It was a typical "smoker's cancer," having undoubtedly been caused by the irritation of the heated clay pipe held constantly in the one position. He came under observation the first week in January, 1894. At that time the growth involved nearly one-half of the lower lip, the ulceration exposing an area as large as a quarter of a dollar, and surrounding induration caused a thickening of the lip to at least $\frac{3}{8}$ ths of an inch. The sanious discharge had been weeping down over the chin, setting up a severe irritation and threatening a general spreading of the condition. The ulcerating surface was at once cleansed with peroxyde of hydrogen, followed by a thorough application of carbolized linseed oil and a free dusting with Arsenic 2x trit. As the ulceration extended over onto the inside of the lip, pieces of cotton saturated with peroxyde were placed between the lip and teeth to prevent irritation from the teeth and to keep the surfaces as clean as possible. These were renewed several times a day as required.

Internally he was given tablets of Arsenic 3x t. i. d., and was furnished with a vial of the carbolized oil and another of the 2x trit., with instructions for its local use at home. He reported at the end of a week, at which time the growth showed noticeable improvement. It was again cleaned carefully with peroxyde of hydrogen and the oil and arsenic applied as before.

He was seen twice after this, at periods of two weeks; improvement was marked at each time and he was discharged, cured, the latter part of February, having been under treatment, practically, two months. He was given another vial of the tablets and continued taking one every day for about a month. The growth was entirely removed, all induration absorbed and the reddened scar tissue soon faded to normal color. He has been seen frequently in the six and one-half years since then and there has never been any indication of recurrence.

CASE II.—L. M.; weaver; native of Quebec; age 47. About twelve years ago noticed a small growth on right side of nose—about size of a pea. It grew very little till he began treatment. About six years ago it was removed by actual cautery, but returned in about four weeks and was soon twice the size of the first growth. A year later he had it cut out, followed by recurrence in four or five weeks, larger than before. Two years before I saw him he had it removed by a plaster. The treatment was very painful but it healed perfectly and gave no trouble for about six months, when it began to grow at upper margin of the old cicatrix. It grew slowly for about a year then began to ulcerate; scabs would form and remain for two or three days, then loosen, and from beneath it would come a thin muco-purulent discharge. When he came to me for treatment, August 28, 1899, there was an open ulcer nearly the size of a ten cent piece, covered by a scab which on removal showed an excavation that would have taken a large marrow-fat pea. The edges of the ulcer were hard and raised. After cleansing the cavity and surface with peroxyde, the carbolized oil and arsenic 2x trit. were applied and 3x tablets given, as in the previous case. Dressing was done twice a week at first, later four times a week. By the last of September the growth was sloughed out except at the upper border and the excavation was filling rapidly with healthy granulations. It was now dressed only twice a week, applying the arsenic only to the point where the growth seemed to persist and dressing the remainder of the wound with calendulated boracic acid powder. Improvement was steady and the patient was discharged November 24, 1899, cured. There has been no recurrence up to the present time and the patient was seen within the past week, looking well.

CASE III.—Mrs. H. R. American. Age 42. History.—On father's side, negative. Mother's sister died of consumption. Another sister died from cancer of breast. Patient always delicate, had usual diseases of childhood and was always troubled with neuralgia. Was married at 18, had no children and has not lived with husband for 21 years; during this time general health has been good. Four years ago had trouble with heart, palpitation, shortness of breath and a persistent hoarseness. She was under treatment for these troubles by several of the best physicians of our city with partial relief. In December, 1898, first noticed a small lump in upper lip near left nostril, which seemed to be between the skin and the inside of the lip. This gradually enlarged, and in course of two or three months extended to the right nostril and ulceration began. She used iodoform, carbolic salve and other "home remedies," under the advice of friends. During this

time she was under the care of one of our best surgeons (not of our school, however), who tried to console her by telling her "not to be frightened till he was," while he prescribed some simple healing lotion.

August 17, 1899, she came to my office for treatment. At that time the entire upper lip was involved. It was thickened to about three times its normal proportions, the color was dark and livid, and ulcerative patches covered the greater part of the surface, extending into the mucous membrane at the lower border and above, involving both nostrils for a distance of three quarters of an inch or more. To the left of the nose it spread upward onto the cheek, and nodules could be found just below the internal canthus. She complained of a great deal of burning and some stinging pains.

Treatment was begun at once, employing the same method as in the other cases. It was dressed twice a week usually, sometimes three times, and the 3x tablets of Arsenic were given internally. Improvement was noticeable after a few dressings and continued rapidly over the lower portion of the growth, but for some time there was a tendency to spreading at the upper border, causing some anxiety as to the possible effect on the eye should extension in that direction continue. This was finally checked, however, before any serious results occurred.

This treatment was continued till near the last of December, 1899, at which time the ulceration was entirely healed, the induration and thickening almost gone, and her general condition much improved. The purplish livid color had changed to a brighter hue, more like normal scar tissue; she was given some of the carbolized oil for local use at home, and the internal administration of the arsenic was continued. About the middle of January a small nodule made its appearance a little way inside the left nostril, but one application of the Arsenic 2x, followed by the application of the oil for a few days, caused its rapid disappearance. The patient has reported about once a month since she was discharged, and up to the present time it seems to be a complete cure. The lip has regained its normal color, and it is only on close inspection that some small lines of cicatricial tissue can be seen. She says that she is feeling better than for years, and works regularly at her old place in one of our large mills.

Three cases cured, or benefited, do not prove the applicability of the treatment to all conditions of this general class; they do show its usefulness in some of these destructive lesions. I regret that I have no personal experiences to relate regarding its use in those cases of malignant ulceration of the breast which

we are too often called upon to treat, owing to the neglect of an early operation.

In one case of deep ulceration of the posterior lip of the cervix, involving the entire posterior vaginal fornix, and threatening perforation of the cul-de-sac, it has seemed to retard the progress of the disease, and at times to almost promise some slight improvement; but this case is still under treatment, and it is too early to report any definite result.

This was one of those unfortunate cases where a radical operation was advised more than a year ago, but refused. The case went elsewhere, received so-called "local treatment," with the result of steady progress of the disease. When she again came under observation the condition had gone too far to render operation advisable, and the "Mitchell treatment" was resorted to only as a palliative measure.

IMPORTANCE OF NASAL RESPIRATION.

BY H. S. WEAVER, M.D., PHILADELPHIA.

(Read before the W. B. Van Lennep Clinical Club.)

THIS natural, simple, easy mode of breathing should be insisted upon as soon as the child is born. The mother and nurse should be taught that the proper way for the child to breathe is through the nose, and when they observe the mouth open it should be gently closed and held until the nasal respiratory function is properly performed. This habit being acquired early in infancy becomes a fixed one for life unless some obstruction develops which prevents a free passage of air through the nose, consequently necessitating an opening of the mouth to properly oxygenize the blood. Frequently the young innocent babes are allowed to cultivate the habit of mouth-breathing because mothers or nurses have failed to close the open mouths of sleeping babes.

When this habit is contracted in infancy and not remedied during early childhood the chances are it will continue during the remainder of life, and may lead them to an early grave by being the predisposing cause of some of the pulmonary diseases.

Animals breathe through the nose by instinct and do not need the careful watching of a mother or nurse to see that it is done properly. Mothers in the savage tribes without the least knowledge of physiology, will sit by their sleeping babes and gently close their lips as soon as they are opened, instinctively knowing that through the nose is the proper way to breathe. Should we, as physicians, who know the physiological changes which take place in the air in its passage through the nose, not be more watchful to have this important function carefully attended to?

Proper respiration is a subject which is very much neglected, and those of us who treat the upper air-passages must recognize the great number of patients who suffer from diseases which are caused from or greatly aggravated by mouth-breathing. It is a habit indulged in by all ages and by a great number of people.

Those of us who have always breathed naturally cannot wholly appreciate the disadvantages and deprivations to which mouth-breathers are subjected. It should be said that one does not live accordingly as he eats but as he breathes. Who has not felt the exhilarating influences of a few long deep nasal respirations taken in the pure open air after being in a close, overheated, over-crowded, unventilated room? These inhalations are felt not only in the nose, throat, larynx and lungs, but they give rise to an increased circulation, a glow or warmth to the whole system, a purifying of the blood and a recharging of the vital energies. On the contrary, we have the mouth-breather coming out of the same room, he naturally fills his lungs with the *same* air, only breathing it in through a different channel, his pharynx, larynx and lungs are chilled by the effect of the cold air on the delicate mucous membrane, and instead of a glow or warmth following the inhalation he is chilled through and not infrequently develops an acute cold.

The normal passages for the air to enter the lungs are the nose, naso-pharynx, pharynx, larynx and bronchial tubes. What simpler, easier and more natural method could we have, and yet how many fail to obey this one of nature's most important laws. All the passages through which the air naturally passes are lined with a delicate mucous membrane giving a large surface with which the air comes in contact before it

enters the lungs, heating it to almost the normal temperature of the body, moistening it when it is too dry, and absorbing the moisture when it is too damp and heavy. The nose is so constructed with the ciliæ as to form a sieve, cleansing the air to a great extent from dust, consequently rendering it the least irritating to the delicate lining of the lungs. Blow your nose after being out for a drive or in some dusty place and you will immediately see how much dirt and dust is prevented from entering the lungs by this wise provision of nature.

Are you surprised that all habitual mouth-breathers suffer to a greater or lesser degree from acute or chronic bronchial irritations, when you pause to consider how much dust and dirt is inhaled into the lungs every twenty-four hours? We all enjoy hearing a clear ringing tone to the speaking as well as the singing voice, and this can only be secured by having a normal resonant nasal fossa, naso-pharynx, pharynx and larynx. To have the above qualities one must continually follow nature's respiratory laws; if they fail in this, the inevitable result must show itself sooner or later in a dry follicular pharyngitis and laryngitis, the extent of the trouble depending upon the duration and persistency of the unnatural breathing.

The causes of habitual mouth-breathing are: Adenoids in the naso-pharnx, hypertrophic rhinitis, tumors in the nose, deflected nasal septi or hypertrophy of the same, abnormal development of the nose, foreign bodies in the nose, hypertrophied tonsils, occlusion of the nares, either congenital or from nasal disease, and lastly, but not least, *habit*. This is the one that we as physicians should fight against. How often are patients seen where all the causes which led to mouth-breathing have been removed, and still the patient continues to keep the mouth open. The children are not to blame, but in a number of cases the parents are, because they have failed to give the child the proper care and attention, simply because the child rebelled against some device which for the time would not be so comfortable to them as the pernicious habit they have so firmly established.

The general facial expression of habitual mouth-breathers is characteristic; the open mouth with contracted upper lip, protruding teeth, chiefly the upper, contracted alæ nasi, with lines running to the corners of the mouth; semi-idiotic, vacant, or

stupid look, especially marked when the hearing becomes affected, as it mostly is when associated with or caused by adenoid growths in the naso-pharynx.

These patients suffer from pharyngo-laryngo-trachial, and in many instances bronchial and pulmonary affections. They are narrow-chested, with shallow respirations, chest-walls sunken, slightly stooped with shoulders well forward, are pale, anæmic and not well-nourished, rendering them weak and nervous, with little or no vitality, no ambition, headaches, weak, toneless or nasal quality to the voice, and at times aphonia. They have frequent colds, coughs, and not infrequently asthmatic attacks.

The above picture is not overdrawn, in many instances simply giving the conditions as found in some of the cases who are typical mouth-breathers.

In presenting this paper I do not pretend to discuss every detail of this important subject, but I do wish to revive some of the half-hearted interest which so many physicians seem to have in reference to this important function. If I succeed in this, many patients will reap the reward by having brighter faces, clearer intellects, healthier bodies, better circulation, clearer voices and freer respiration.

It is not within the scope of this paper to take up the treatment of these conditions; suffice it to say that each case must be taken up understandingly and carefully studied until the cause is ascertained. When this is done, remove it, and then insist upon the patient breathing through the nose. This can be accomplished by calling their attention to it during the day at frequent intervals, and at night have them wear a support which will hold up the jaw, forcing them to breathe through the natural channels.

PICRIC ACID IN SUPPURATIVE OTITIS.—Dr. Lanoix asserts that picric acid is not only analgesic and antiseptic, but also keratoplastic, and in suppurative ear affections he has noted where a canterizant action was indicated, and astonishingly good results. He employs the following solution: Picric acid, 0.2; dilute alcohol, 2.0; distilled water, 20.0. Instill a few drops, and leave it a few minutes in contact with the mucous membrane. The great desquamation which follows requires frequent cleansing of the canal of the ear. It is only contraindicated in cholesteatoma.—*Muenchener Medicinische Wochenschrift*, No. 8, 1899.

EDITORIAL.

WM. H. BIGLER, A.M., M.D.

WM. W. VAN BAUN, M.D.

A HOMŒOPATHIC PHYSICIAN.

It was with difficulty that we refrained from giving vent to the indulgent amusement with which we curiously watched the birth and development of the Definition of a Homœopathic Physician. Our sympathetic temperament forbade us to interfere with an innocent, and, so far as we could see, harmless pastime, on which only much paper, ink, and space, and some ingenuity were being wasted. Now, however, since the self-complacency of our medical lexicographers has been so ruthlessly disturbed by another, by the author of *Is Our Materia Medica Becoming One of the Lost Arts?* (H. M., October, 1900) we feel that we may be allowed to add some remarks. It struck us when the defining first began that it bore a striking resemblance to the issuance of fiat money—the endeavor to make a shinplaster pass as an equivalent for good metal by an authoritative stamp. So long as our dealings are confined within our own borders such things will serve as a convenient medium of exchange, just as beads or shells have done among less civilized peoples; but when we are brought into contact with others, whose standard of values differs from our own, then only that which has intrinsic worth can pass current. So here in this matter of the definition of a homœopathic physician, if it is at all necessary, it is quite proper to stamp him as erudite, as skillful, as scientific, and as perfect in all respects as possible—good for the payment of all debts, public and private, to homœopathy, to allopathy, to science, and to humanity—but only, so to speak, for private circulation. Amongst ourselves let him be all that and as much more as space allows, but we cannot expect him to pass as legal tender in that shape amongst foreigners. These demand the real thing. The beautiful scroll-work on our greenback will not ensure its acceptance. It may be all very pretty, but they want real metal, and will hardly be satisfied even with the silver cart-wheel. The size of our definition will not help its currency.

But we are not wholly in accord with the definition offered

by the author of the paper above referred to. He says: "A homœopathic physician is one who practices homœopathy—this, and nothing more; but all of this." That is very good as far as it goes, but it is like the gold dollar, it don't go very far alone; it is too small, and must be wrapped in something else to give it bulk and to prevent its being lost.

This definition is not in accordance with present usage, for we do not, perhaps unfortunately, limit the name Christian to those who practice Christianity, but mercifully extend it to those who theoretically believe in the truths of the Christian religion, while their practice of them is limited by their ability and modified by circumstances. Rev. Sheldon would find it an impossibility to discover a definite gospel precept to guide him in meeting every issue of our present civilization. He must go back of the letter and act according to the spirit. So must we. We cannot hope to define a homœopathic physician until we can unanimously define homœopathy. Many think this an easy task, and point with confidence to the *Organon* and to the other writings of Hahnemann. But these give us not homœopathy, but Hahnemannism, as we never tire of emphasizing; and even these writings cannot be made to adapt themselves literally to the demands of present medical science any more than the letter of the gospel to the civilization of the present day, while they dare never lay claim to infallibility, as it has done.

Hahnemann discovered (not invented) the principle of homœopathy, and with wonderful genius and acumen proceeded to unfold it according to his own personal views, which views frequently underwent changes and modifications, as was to be expected, in the light of his ever enlarging experience while practicing homœopathy. (No more instructive or entertaining reading in this connection can be found than Bradford's "Life of Hahnemann," as it appeared in the *Recorder* a couple of years ago.)

Has Hahnemann pre-empted all claims in the field of homœopathy? Has he exhausted the entire mine? Are there no "leads," no "pockets," which may have escaped his notice? If the field is really incapable of further development, if the mine is really exhausted and we are called upon to be satisfied with the treasures taken out nearly a century ago, then had we better pull up stakes and search for more promising territory. The teachings of many of our school would seem to imply that such is the case, and hence we find so many restless dwellers in our camp, swayed by every rumor of new "finds" elsewhere, ready and anxious to depart to other fields where they may dig for themselves and "strike it rich." But homœopathy is not an exhausted mine. Hahnemann was only a pioneer. He worked as few are capable of working, and collected much treasure, an almost incredible amount when we consider the

means at his command. Are we, therefore, not to be allowed to seek to add to this treasure, and in doing so are the instructions of Hahnemann as to the manner of working this field to receive no modification, no improvements from the advances made in general medical science? Change in methods is often followed by change in results—if not in the final results, at least in some of the by-products.

As we wrote more than a quarter of a century ago, the science of homœopathy can only be developed by developing and defining the contents of the three words in which its principle is expressed, *similia similibus curantur*. What are included in the *similia*, symptoms or conditions, causes or effects, etc.? This opens up the whole question of pathology and semeiology. In the *similibus* we have included the whole realm of materia medica, with the primary and secondary effects of drugs, organic and functional disturbances resulting from drug action, etc. What is meant by *curantur*? Even the signification of the Latin word is not universally agreed upon. Is it treat or cure? If cure, does it promise relief of symptoms—palliation—or the removal of the cause of symptoms—actual cure? (We know what Hahnemann said, so please do not go to the trouble to refer to some paragraph in the *Organon*.) Here we have the whole field of therapeutics opened before us. Surely there is plenty of work yet to be done, and science has put into our hands improved methods and instruments whereby it can be done better, more thoroughly and more convincingly than ever before. Therefore, he who labors in this field, guided by the principle of homœopathy, is a homœopathic physician, not necessarily one who is content to use without question the methods and results of the labors of a dead and gone prospector. *Esse non videri*—to be, not to seem—should be our motto. Theoretical adherence to the principle of homœopathy, and its practical application according to his knowledge, with a determination to be restricted by no dogmas in his search for the truth, are all-sufficient to constitute a homœopathic physician.

DR. BARTLETT EDITOR OF THE HAHNEMANNIAN MONTHLY.

WITH this number of the HAHNEMANNIAN MONTHLY Dr. Van Baun's services as editor will cease. While thanking the friends of the journal for their sustaining loyalty and generous assistance during his ten years' service, he asks for his personal friend, Dr. Bartlett, their continued favor and support both as contributors and subscribers. Dr. Bartlett's well-known ability as author and editor is the best possible guarantee for the successful future of the HAHNEMANNIAN.

GLEANINGS.

THE ÆTIOLOGY OF MALARIA.—According to Thayer, it is certain :

1. That the malarial parasite possesses an extra corporeal cycle which is completed in the stomach-wall of mosquitoes of the genus *Anopheles*.
2. That members of the genus *anopheles* can transmit malaria from infected to non-infected individuals.

At present this is the only proved method by which malaria can be acquired. This theory explains most of the conditions associated with malarial infection ; reports of the protective efficacy of mosquito-nets even in the most malarial districts are accumulating rapidly ; there is no serious evidence in support of any other theory.

The evidence at present tends to favor the theory that the mosquito can acquire the infectious agent only from man. The statement is often made that in tropical Africa, for instance, exploring parties may spend considerable periods of time in the uninhabited interior without illness, even though the regions may appear, from outward conditions, most unhealthy. It is only on their return to the seacoast, to districts where the surroundings would appear to be better, that the outbreaks of malaria occur. This hitherto inexplicable fact becomes clear if one assumes that in the woods, though all conditions are present for the spread of the disease, the mosquitoes are uninfected and so harmless ; it is only on coming back to the settlement where infected mosquitoes are present that the disease breaks out. Studies by Celli and Delpini, by Grassi, by Bastianelli and Bignami, of epidemics in small communities have shown that the vernal cases of malaria are almost all relapses ; that during the month of June the *anopheles* begin to be active, and that about a month after the beginning of the activity of the *anopheles* the true epidemic begins, starting apparently in foci about individuals who have recently suffered from relapses of the disease. During the season in which *anopheles* flourish the malarial epidemic prevails, only to disappear again with the disappearance of the mosquitoes.—*Philu. Med. Journal*, May 5, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF TYPHOID FEVER IN JOHNS HOPKINS HOSPITAL.—Osler, summarizing the cases of typhoid fever treated in Johns Hopkins Hospital during the past ten years, states that there were 63 deaths in 829 patients, a total mortality of 7.5 per cent. This includes the group of cases met with in all general hospitals, to which patients are frequently admitted in a moribund condition, or so ill that death occurs within three or four days.

The treatment consists in :

1. A careful and thorough system of *nursing*, to which, as much as to any other single feature, Osler attributes the comparatively low rate of mortality for a general hospital.
2. *Diet*.—Milk, diluted with lime water, and egg albumin form the standard diet of the febrile stage. Artificial foods are rarely ordered. The milk has

not often to be peptonized, and on the whole there have been singularly few gastric complications, and comparatively few instances of serious bowel trouble. The patients are given in addition an abundance of cold water.

3. *Hydrotherapy*.—Either the full tub at 70°, or, if occasion requires, ice-cold sponges.

4. *Drugs*.—As a rule no medicines are given. If the pulse becomes rapid and feeble alcohol in the form of good whisky, and strychnia in full doses, if necessary, are given. No antipyretics and no intestinal disinfectants are used. Special complications require and receive appropriate treatment.—*Phila. Med. Journal*, October 13, 1900.

F. Mortimer Lawrence, M.D.

OPIMUM AND CHANGE OF PERSONALITY.—A curious and very suggestive case is reported in the *Revue d'Hyponotisme* of a young woman who several times became a victim of the opium habit. At such times she exhibited a character and habits entirely unlike those of her normal and healthy condition. In the latter she was restless, fond of change and travel, impulsive, passionate and addicted to jealousy. As soon as she began to use opium she became quiet and sedentary in habits and tastes, careful and calculating in matters of money, instead of lavish and reckless as before. Having been cured of the opium habit she became at once her former restless, impulsive, passionate and unreasoning self. Becoming again an opium user, she was immediately transformed into a shrewd, cautious manager of her affairs, reason and reflection dominating instead of impulse and passion; and these phenomena reappearing again in subsequent years as she gave up or resumed the use of the drug. The question would naturally arise to the psychologist, was not the morphine state of her personality the superior one both from the moral point of view and that of functional equilibrium? and to the therapist the history of this case might furnish a valuable suggestion.—*Med. Times*, October, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF THRUSH.—Escherich states (*Jour. A. M. A.*) that the promptest and most effective method of curing thrush and cleansing the mouth is to put a little boric acid and saccharin on a sterilized rag and give it to the infant to suck.—*Med. Times*, October, 1900.

ASPARAGUS FOR ŒDEMA.—Hare (*Therap. Gaz.*) has used an extract made from the tops of asparagus in cases of general œdema, with good effect upon the kidneys. The amount of urine was generally increased in the course of a few days.—*Med. Times*, October, 1900.

SALT VERSUS BROMIDES.—The *Journal A. M. A.* calls attention to Richet's recent announcement that the bromides can be rendered doubly effective in the treatment of epilepsy by depriving the patients of salt in their food. Roux confirms this statement and states that the simplest manner of depriving the food of salt is to place the patients on a milk diet. He found very small amounts of bromides effective in arresting and preventing seizures when combined with a milk diet, while if salt were added to the milk the seizures appeared in one of his four patients.—*Med. Times*, October, 1900.

F. Mortimer Lawrence, M.D.

DILATATION OF THE PUPILS AN EARLY DIAGNOSTIC SIGN OF TUBERCULOSIS.—Harrington (*Phila. Med. Journal*, April 28, 1900) calls attention to the occurrence of a widely dilated state of both pupils as an early sign of

tuberculosis, and Luhan confirms his observations in a later issue of the same journal. He adds that the dilated pupils are invariably associated with peculiarly bright and glistening eyes which show great susceptibility to the stimulus of light.

F. Mortimer Lawrence, M.D.

THE PATHOGENETIC EFFECTS OF COFFEE.—Combemale (*Echo Med. du Nord*, March 11, 1900) records the case of a man who was admitted under his care on account of giddiness, which came on suddenly in the street. The case was taken by the police for one of intoxication. On admission he was noticed to be extremely thin, and he suffered from vague pains in the limbs and loins, intense headache, generally worse at night, and most marked in the temporal regions, which he described as a heavy cap pressing on his head. It prevented his sleeping more than two hours or so in a night. He dreamed considerably, and stated that he always saw grotesque animals passing before him. Pressure over the calves elicited considerable pain of a muscular character. The reflexes appeared to be normal, and there was no alteration of sensibility. There was no tremor; the gait did not present any marked characters other than a slight heaviness. There was no Romberg's sign. The lungs showed slight degree of emphysema. There were no valvular lesions of the heart nor alteration of rhythm. The man was by trade a rag gatherer. This description corresponds with that given some years ago by Guelliot—namely, emaciation, paleness of the face, some tremor of the lips, muscular pains, and vertigo as occurring in cases of chronic caffeism. In this case the patient was in the habit of going from house to house where the contents of the coffee-pot were reserved for him, which he was in the habit of consuming in large quantities. The literature on this subject is not extensive; in fact, the condition has not been widely recognized; but Combemale was able to quote references to the condition, especially those of Viaud (*Tribune Médicale*, 1897). He finds that intense vertigo, which may be mistaken for Ménière's disease, and very marked bradycardia, are characteristic of chronic caffeism. There is also ringing in the ears, a sensation of falling, and other evidences of alteration in the central nervous system. Mendel is also quoted by the writer as noticing general weakness, distaste for work, mental depression, insomnia, tremor, palpitation, coldness of the extremities, symptoms of dyspepsia, obstinate constipation, as present in this condition. The prognosis seems to be good, as, on avoiding the use of coffee, these various manifestations of intoxication rapidly disappear, though recurrence is common.—*Brit. Med. Journ.*, May 5, 1900.

F. Mortimer Lawrence, M.D.

ERGOT IN PNEUMONIA.—A writer in *Practical Medicine* relates his experience with ergot in pneumonia. He first tried it on a negro, who had had a chill that morning; his temperature was 104°, respirations 45 per minute, pulse, 120; he was coughing up the characteristic sputum, and complained of terrible pain in the right side. Physical examination showed that the lower lobe of the right lung was involved. A teaspoonful of ergot with two drops of aconite brought relief in twenty minutes. He was then given two drops of ergot with one-half drop of aconite every two hours, and next day his pulse was 96, respiration 22, and temperature 101 $\frac{2}{3}$ °, with a general improvement of symptoms. Three days later the patient was about. Since then he has used ergot in nearly every case of pneumonia; in ten years he has lost

but four cases, in two of which ergot was not given, and two others of which followed measles.

The *Eclectic Med. Gleaner*, August, 1900, copies the above, stating that our knowledge of the action of ergot suggests its possible value in the early stages of pneumonia.

F. Mortimer Lawrence, M.D.

IBERIS AS A HEART MEDICINE.—Proctor notes that in the literature of our school there is hardly any mention of iberis used therapeutically. This may be due to doubt thrown on the provings. He has had an experience in his own case, however, which has made due impression on his mind. He was seized with influenza in 1890, but after throwing off the acute attack and being subject to the usual depression for a month or so, he hoped he was out of the wood. But unhappily heart weakness supervened and became a great trouble to him. For over two years almost every waking moment was attended with cardiac distress. The persistent weakness developed on the least agitation into irregular palpitation with great anxiety: Arsen., quinine, strophanthus, cactus, digitalis, and many other remedies were tried with very little alleviation. Several sphygmograms were taken, and showed want of cardiac impulse and occasional irregularity. Finally, at the end of two years, he was led to try iberis, a drop of the mother tincture two or three times a day. After continuing this for about ten days as the sole treatment, the heart fell almost suddenly into its proper, regular and unconscious beat, the asthenic symptoms vanished, and he has not been troubled again. He has repeated the treatment with success in many cases. He thinks that the provings and his own case point to its use in asthenic cases as a purely cardiac drug having no vaso-constrictor action.—*Hom. World*, November 1, 1900.

F. Mortimer Lawrence, M.D.

PHENYLHYDRAZIN AND ANEMIA.—The many attempts that have been made to produce experimentally the clinical picture of pernicious anemia are not without possible therapeutent value. Fallquist used pyrodin, and now Kaminer and Rohnstein (*Berlin Klin. Woch.*, July 30, 1900) report the use of phenylhydrazin. A large dose injected into animals produced death in forty-eight hours, and during this time the red corpuscles sank to one million and even lower. Within six hours after the injection fragmentation of the red corpuscles and macrocytes was visible, but there was no poikilocytosis, although there was moderate leukopenia. There was also a marked polychromasia of the red corpuscles in the stained preparations; some did not stain at all. Nucleated red corpuscles, chiefly normoblasts, but also megaloblasts, appeared. If the dose of poison injected was smaller a chronic anemia could be induced, consisting in a reduction in number of red corpuscles and the appearance of macrocytes; no poikilocytosis was obtained, nucleated red corpuscles were rare, and the leucocytes were increased generally. Phenylhydrazin seems to act upon the leucocytes in a manner similar to that of toxins, in large doses as a negative chemotactic, and in smaller doses as a positive chemotactic agent.

F. Mortimer Lawrence, M.D.

A SIMPLE METHOD OF BLOOD EXAMINATION.—In the *Phila. Med. Journal* (October 20, 1900), Watkins, of New York, quotes Fussell as saying, "By the use of a microscope and a slide of fresh blood one may observe: First,

whether the leucocytes are largely increased in number; second, whether the red cells form properly in rouleaux." Watson then recommends a method which is certainly simple, although its effectiveness in many cases may be questioned. It is this: In healthy blood, using a one-sixth objective, there are visible on an average one or two leucocytes to every microscopic field. Anything more or less than this is abnormal. Assuredly this is much easier than the use of the Thoma Zeiss apparatus; but it would seem that only great variations in the count could be determined.

F. Mortimer Lawrence, M.D.

INTESTINAL OBSTRUCTION AND ATROPINE.—Dr. Batsch, who has for some time advocated the great usefulness of atropine hypodermically in cases of intestinal obstruction, reports the case of a woman of a distant village who for a day had been able to pass neither flatus nor a stool. She had vomited often cheese-like and fæculent masses, and her abdomen was very painful without a definite localization of the pains. Her pulse was observed to be 110, temperature 37.2° C., and her facial expression indicated suffering. Neither on palpation nor percussion could abnormal resistance in the abdominal cavity be detected. No signs of a hernia, nor was anything to be felt in the rectum. Opium was administered, 0.04 every two hours, her stomach washed out and a high clyster injected, which was retained. The following day her condition was still worse. She persisted in vomiting foul-smelling and thin fæcal fluid; her strength failed, her pulse was 130, temperature the same, hippocratic facies, in great pain but fully conscious. An operation was refused, but after much discussion it was agreed if by the next day no stool had been passed that she would consent. On his way home the atropine method of treating intestinal obstruction came to him, and as he had promised to send some medicine, he ordered: infusum belladonnæ, 1.5: 100 every two hours, and extr. belladonnæ, 2.0: butyr. cacao q. s. to make ten suppositories. One every two hours. The following day he drove out to the little country village with a feeling of uncertainty, such as one would experience after such a therapeutic venture. He breathed freely when he heard that the patient, though restless and unable to see well, had had a copious stool. It was thin, tinged with blood, darkish brown and green as well as stinking. The woman had a rapid pulse, no fever, mild delirium, dilated pupils and a soft abdomen. He administered small doses of atropine, stimulants, and for fourteen days she suffered from a catarrh of the bowels, which was probably due to the atropine. Here he has no doubt that the belladonna was the means of removing an intestinal obstruction where laparotomy would have been too much for this weakened patient to have borne.—*Muenchener Medicinische Wochenschrift*, No. 35, 1900.—(Dr. Batsch has recently warmly advised large doses of atropine hypodermically in ileus, and he has reported several cases where they have brought about good results in seemingly desperate cases. He administers doses which are far beyond our maximal ones, and yet with but little inconvenience. Hyoscyamine and strychnine I know to have been used with good results in such a case.)

Frank H. Pritchard, M.D.

HÆMORRHAGIC NECROSIS OF THE INTESTINE FROM VENOUS THROMBOSIS.—Dr. Hi, from observation of a case of this condition, thinks that a diagnosis during life is not impossible. There are characteristic attacks of pain which

appear more or less spontaneously, and which may be aggravated by palpation of the abdomen. This pain radiates into the loins and back, even into the epigastrium and hypochondria. Whenever thrombosis of the portal veins is added to a hepatic affection its symptoms complicate the latter condition. At other times the pain itself alone occupies the foreground, making one think an appendicitis, hepatic colic or intestinal obstruction is present. In all the known cases of primary venous obliteration, death followed with a so-called terminal syndrome; violent lancinating pains in the lower bowels, and vomiting, would lead one to diagnose a peritonitis. The appearance of these symptoms, after a period of pain of two or three weeks, should lead one to diagnose hæmorrhagic necrosis of the intestine from venous thrombosis. He does not regard the infection as of intestinal origin.—*Revista Critica di Clinica Medica*, No. 31, 1900.

Frank H. Pritchard, M.D.

LATE ENLARGEMENT OF THE LYMPH-GLANDS AS A SIGN OF THREATENING NEPHRITIS IN SCARLATINA.—Dr. L. Stembo has noted in some epidemics that there is a premonitory swelling of the lymph-glands of the neck during convalescence of scarlatina. The child may have neither fever nor albuminuria, nor any other symptom, when all of a sudden the cervical glands enlarge, at times considerably, as well as those of the back of the neck, either of one or both sides. Less rarely the inguinal glands swell. With this there is a moderate degree of fever of a continuous type. At the beginning the urine remains normal, and only after one to two or even three days is albumin noted and the quantity of urine decreases. With these renal disturbances, which rapidly become worse, all the characteristic signs of a nephritis appear. At times anasarca may be absent, even with complete and even fatal anuria. On account of this sign being absent in some epidemics, its absence would not be conclusive, yet it would be worth searching for.—*La Semaine Medicale*, No. 26, 1900.

Frank H. Pritchard, M.D.

THE BACTERIOLOGY OF THE INTESTINES OF YOUNG CHILDREN.—Dr. H. Tissier, of Paris, in normal children nursed by their mothers has found that from the fourth day of their existence until weaning one may detect bacteria of the anærobic variety, the bacillus bifidus, which predominates, and the facultative microbes, the bacillus coli, the intestinal streptococcus, and the bacterium lactos ærogenes. Under the influence of calomel or of irrigation of the intestine the streptococcus diminishes and the bacillus coli continues to thrive.

In children who are bottle-fed the varieties are quite varied; bacillus acidophilus, bacillus exilis, the streptococci, coli-bacilli, etc.

In cases where mixed feeding is employed the intestinal flora resembles that of breast-fed children. In the course of gastro-enteritis a modification like that following the use of calomel is noted; besides, other micro-organisms appear which have not been noticed in normal stools: diplococcus griseus liquifaciens, coccobacillus, anærobicus perfringens, a streptococcus decolorated by Gram's method, the special variety of coli-bacillus described by Hermann and Wurtz, etc.—*La Semaine Medicale*, No. 37, 1900.

Frank H. Pritchard, M.D.

POISONING BY IODOFORM IN A CHILD SIX WEEKS OLD.—A physician was called to a child two weeks of age where, after circumcision had been done, as the wound healed slowly a yellow salve had been applied locally. The next day the child was somnolent, with grinding of the teeth, and when he was called it was comatose, cyanotic, with shallow respiration and retraction of the epigastrium; its temperature was 37.8° , its pupils greatly contracted. Poisoning by opium, which it closely resembled, could be excluded; and as there was a strong odor of iodoform about the child, while the under surface of the penis, scrotum and the insides of both thighs were covered with a hæmorrhagic eczema, mustard baths, hot colon flushings and brandy in drop doses were ordered, and on account of its resembling so closely poisoning by opium, belladonna was given. The next day the child was about well; the eczema had greatly improved. He calls attention to the value of spasm of the larynx as a symptom of poisoning by iodoform as well as the contracted pupils and the apparent antidotal action of belladonna.—*Hospitalstidende*, No. 23, 1900.—(Some German writers warn against using either iodoform or carbolic acid in children. Schmaltz and Schweissinger, *Die Arzneimittel*, 1893, p. 115, state that poisoning by iodoform may occur from absorption from wounds, eczematous surfaces, serous cavities, etc., and especially readily in old persons and those with damaged kidneys. They give headache as characteristic, and gastric disturbances; in large doses nervous and psychic conditions of depression and irritation may follow, which in rare cases may become permanent, and after long use fatty degeneration of the heart has been noted. On the skin it easily causes dermatitis. In the urine much iodide of sodium is to be detected. Harnack recommends the bicarbonate of potash to counteract its influence chemically, 5.0 : 100.0, as a beverage.)

Frank H. Pritchard, M.D.

CHRONIC POISONING BY SULFONAL.—Dr. Dietrich has collected data on chronic poisoning by sulfonal, comprising fifty severe cases of poisoning and thirty fatal ones. The fatal dose and time necessary for action vary greatly, for one patient took 224 gms. in 205 days, while another died after 90 days from 90 gms. The danger increases from constipation. Herting records a post mortem where there was great swelling of the mucous membrane of the stomach and intestines, with scattered hyperæmic spots. This case is of interest, for the first symptoms that we notice are gastro-intestinal catarrh. At about the same time a dark-red appearance of the urine sets in. The patient may die from increasing coma or suddenly appearing heart-failure. The curious coloring-matter in the urine, hæmatoporphyrin, has been demonstrated by Salkowski, etc., to be identical with hæmatin free from iron. If sulfonal be administered for a long time it should be discontinued about every month. If poisoning has already taken place it should be quickly eliminated by giving soda-water, diuretin, rectal injections and hypodermic infusions of a solution of sodium chloride (7 per mille.). Otherwise the treatment is chiefly symptomatic, with especial care as to the heart.—*Hospitalstidende*, No. 26, 1900.

Frank H. Pritchard, M.D.

SECONDARY HÆMORRHAGE FOLLOWING USE OF SUPRARENAL EXTRACT.—Hopkins (Springfield, Mass.) reports three cases of secondary hæmorrhage following the use of suprarenal extract in operations in the nose. All the operations were for the removal of exostoses from the septum. A mixture

of cocaine and suprarenal extract was used with primary gratifying results, but in each case a smart secondary hæmorrhage occurred, requiring the use of a pack for its control. He has also noticed that some patients present an idiosyncrasy against its use, violent coryzas following its application to the nasal mucous membrane, thus illustrating the relaxation that may follow the primary stimulation induced by the suprarenal extract. The author has collected a number of experiences on this point from representative laryngologists in various parts of the country, and the consensus of opinion was that secondary hæmorrhage did occur after the use of the extract, and that the more prudent will take no chances but pack the fossæ before allowing the patient to leave, thus forestalling any accident. In one of his cases the hæmorrhage was alarming; the patient seemed much prostrated, and was confined to the house for three weeks following the operation. The writer therefore recommends that the nasal fossa be packed after every operation. His own preference is for the employment of a packing saturated with an astringent.—*The New York Medical Journal*, August, 1900.

Gustave A. Van Lennep, M.D.

THE TREATMENT OF TUBERCULOUS AND PURULENT JOINTS WITH LARGE GLASS-SPECULUM DRAINAGE-TUBES AND PURE CARBOLIC ACID.—Phelps (New York) lays great stress on the value of crude carbolic acid in the treatment of tuberculous joints, and suppurating processes of bones and joints, especially when combined with the thorough drainage obtained by means of the introduction into the wound of large glass-speculum drainage-tubes. These not only serve to keep the soft parts well separated and allow the surgeon to carefully examine and treat the wound to its very bottom throughout the entire period of its granulation but also greatly lessen the pain attendant upon dressing and packing the wounds.

The method of its application is this:

"The abscess cavity is laid open, the opening into the capsule is found and enlarged and the joint explored. [The author here refers to the hip.] If there is extensive bone disease, the incision is lengthened and the capsule of the joint freely divided for half or two-thirds of its circumference, the head of the bone pulled out from the socket, the curette freely used, and the joint thoroughly irrigated with bichloride solution, 1-1000. The joint is now filled with crude carbolic acid. It is allowed to remain one minute by the watch, after which the joint is thoroughly washed out with pure alcohol, and finally the alcohol is washed away with a 2-per-cent. solution of carbolic acid."

The glass drainage-tubes the author uses are made in sizes varying from one-quarter inch to two inches in diameter. The largest tube is for an adult excision of the hip and five inches long. The one- and one-and-a-half-inch tubes are for excisions in children, and three inches long. The other tubes are used when joints are opened and not excised, and are of various lengths. Judgment must be exercised in selecting the tubes. The largest tube that the cavity will take, which extends to the bottom of the joint, and is flush with the skin, should be used. Through this the joint can be treated by curetting, and the application of carbolic acid and alcohol, whenever further suppuration or extension of disease takes place. The tube is worn until granulations fill in from the bottom of the wound.

The author has also used carbolic acid and alcohol in the treatment of ery-

sipelas, as suggested by Powell, of New York, and has found it "as much a specific for that disease as quinine is a specific for malarial poisoning."—*New York Medical Journal*, September, 1900.

Gustave A. Van Lennep, M.D.

THE SUTURE AND THE VALUE OF DRY STERILIZED CATGUT (Carstens, Detroit).—The catgut is put into ether for a few days or a week, till the fat is all removed, and then cut into strips 18 or 20 inches long. Three of these are wrapped in fine tissue paper. This is then placed in a small envelope, the latter closed, and then placed in the Boeckmann sterilizer and subjected to dry heat for three hours. The thermometer is kept in the apparatus, so that one can see that the heat is at least 300° F. At the expiration of that time the heat is shut off and the ligatures remain in the apparatus without disturbance for from twelve to eighteen hours, which gives any spores that may be present an opportunity to develop. Then the heat is again used, and the sutures are subjected to a heat of 300° F.

The points specially emphasized are :

1. All buried sutures ought to be absorbable.
2. All absorbable sutures must be absolutely sterile.
3. Chemicalized sutures are no more sterile than plain sutures.
4. A suture that is chemicalized is harder and remains longer in the tissues.
5. This latter is no advantage, but a disadvantage. If in a special case it is desirable that a suture should remain longer, dry sterilized kangaroo tendon can be used.—*N. Y. Med. Jour.*

Herbert P. Leopold, M.D.

CORNEAL INFECTION.—Dr. W. E. Briggs gives the following practical points on the treatment of corneal infection :

1. All corneal infection, in the absence of constitutional disease, comes from without, and gains entrance through some lesion of the epithelium. Every corneal wound should therefore be thoroughly cleansed with a mild antiseptic solution and an antiseptic compress applied.
2. Injuries of the cornea are especially dangerous in the presence of suppurative disease of the conjunctiva or lacrimal sac. Active measures must at once be taken to render the wound antiseptic and to prevent new infection.
3. When the infection of a corneal wound has become established, the active focus should be treated with strong antiseptics. In grave cases the galvano-cautery offers the most effective means.
4. When patients complain of having "taken cold" in the eye, that organ should be carefully examined for foreign bodies and corneal abrasions, the most minute being readily detected by the introduction of fluorescein solution. Sulphide of zinc or other irritants should never be prescribed until the existence of a wound has been positively excluded.—*Occidental Medical Times*.

Wm. Spencer, M.D.

THE ACTION OF DIONIN AS AN OCULAR ANALGESIC.—Hoping to obtain a stimulating effect upon the lymphatic system, and thus favor the absorption of atropin in a rebellious case of iritis, Darier discovered by accident that dionin possessed remarkable analgesic properties, which lasted for two days. At the same time, after its application, he says, the eye improved rapidly.

The result led to other experiments. He believes that until the time that experimentation shall have given a precise explanation of the mode of action

of dionin, it is sufficient for us as clinicians to know that we are in possession of a powerful ocular analgesic which is capable of allaying for long periods of time the most violent pains that are produced by iritis, irido-cyclitis, ulcers, keratitis, and glaucoma. This discovery, he states, is due to the clinical observations solely.

His method consisted in the placing of a small mass of the powder, "about the size of a grain of wheat," in the conjunctival *cul-de-sac*. This application was usually followed by a primary blanching and later an intense chemosis and swelling of the conjunctiva. The latter symptom soon passed off, and in about an hour's time the patient was feeling comfortable. In many instances the relief from pain would last for a period of two days.—Darier, Paris, *La Clinique Ophthalmologique*.

William Spencer, M.D.

SECONDARY CATARACT.—Dr. W. H. Bates has been making some experimental study in the ætiology of secondary cataract. The work has been carried on at the Pathological Laboratory of the College of Physicians and Surgeons, Columbia University, N. Y., using rabbits as material. He describes his technique and gives drawings of the gross and minute sections. His conclusions are:

1. Secondary cataract in the rabbit is composed of new connective tissue, together with the folded posterior capsule of the lens. But the opacity of the structure occupying the pupillary area is due to the new connective tissue, and not to the capsule.

2. The formation of secondary cataract in the rabbit begins with the accumulation in the anterior chamber of a coagulable fluid at the time of operation. Fibrin appears in the pupillary area from the coagulation of the fluid. Later, new connective tissue replaces the fibrin.

3. The prevention of secondary cataract in the rabbit may be secured by performing a quick operation, closing the scleral or corneal wound with sutures and restoring the anterior chamber with normal solution. The studies recorded in this paper have been limited to the rabbit, and while they afford a strong presumption that secondary cataract in man also is due to formation of new connective tissue in the pupillary area, this can be definitely determined only by the study of human material. This study is now under way.

If the author's observations are correct, it may lead to a revival of the use of suture to close the corneal wound after cataract extraction. Such closure is desirable on theoretical grounds, if it can be accomplished without adding to the risk of poor results from the operation.—*New York Medical Journal*.

William Spencer, M.D.

VISUAL AND OPHTHALMOSCOPIC EXPRESSIONS OF CARDIAC ORIGIN.—The patient studied by Valude was a man of thirty-nine years of age. His face was cyanosed, and the conjunctivæ were of a yellowish-red color, with marked pericorneal injection. Examination revealed an hypertrophied heart, but without valvular lesion. The urine contained neither sugar nor albumin. Vision was reduced to one-half of normal in the right eye and to one-twentieth of normal in the left. Both eyes were practically emmetropic. Ophthalmoscopic examination revealed a remarkably varicose condition of the retinal veins with some dilatation of the corresponding arteries. The veins were so dilated that they covered almost the entire ophthalmoscopic field. Vision

fluctuated somewhat, though it was better in the right eye. In somewhat over a month after the admission of the patient to the hospital, he died.

The autopsy revealed an exceedingly dilated heart, with thickened and sclerosed walls. There were no valvular lesions. All of the thoracic and abdominal viscera offered the characteristic conditions which would accompany such a heart. The brain was exceedingly congested. Its convolutions were filled with dilated and tortuous veins. On washing the brain a blood-discolored spot was noticed around the fissure of Sylvius and the angular gyrus on both sides, extending in one direction toward the occipital lobe, and in the other toward that portion of the frontal lobe which lies under the anterior ascending convolution. These portions of the brain were almost black from extravasated blood, although the entire surface of the organ was the color of wine dregs. On section of the brain, particularly in the right hemisphere, the gray substance corresponding with the angular gyrus was of a violet tint, this being due to petechial hæmorrhages. The region of the occipital and the ascending convolutions were also slightly marked in the same manner, but not to such great degrees. There was no change in the striated bodies or in the optic tract.

The ventricles were normal. The author believes that the lowered visual density was due to the central lesions.—Valude, Paris, *Annals d'Oculistique*.

William Spencer, M.D.

APPENDICITIS DURING GESTATION, PARTURITION AND CHILD-BED.—Dr. Oscar Semb, from experience gained in two cases, both fatal, and a perusal of the literature, thinks that pregnancy does not predispose to appendicitis, but on the contrary chronic appendicitis is possibly more liable to relapse during gestation, and also may increase the danger when the affected area is near the uterus and adheres to it either directly or indirectly. Parturition may bring about rupture of protecting adhesions, or of a gangrenous appendix. The infection may reach the uterus from the appendicular spot. Abortion is the rule in severe cases, but in the catarrhal form the exception. The frequency of miscarrying has been exaggerated. As statistics are lacking, and as usually only the serious cases are published, we tend to exaggerate the dangers of appendicitis in pregnancy. Operation is not necessary in all cases, for it is certain that benign catarrhal ones recover without it. In recurrent and serious cases an operation is advisable.—*Norsk Magazin for Lægevidenskaben*, No. 6, 1900.

Frank H. Pritchard, M.D.

THE MANAGEMENT OF NORMAL LABOR, INCLUDING THE USE OF THE FORCEPS (Flint, New York).—1. The importance of making a diagnosis and a complete physical examination about one month before the onset of labor.

2. Infrequent examinations during labor. An ante-partum douche is not only unnecessary, but is actually harmful. The use of gloves has not been satisfactory.

3. The use of anæsthetics should be more general in private practice. Ether possesses many advantages over chloroform, and should be used, as a rule, when the pains are of moderate intensity.

4. In the hands of the general practitioner, a low forceps operation should be performed with greater frequency. It is easy of execution, is devoid of danger, saves unnecessary suffering on the part of the patient, and often

actually enables us to preserve the perineal flow intact. On the other hand, however, median operations within the cervical canal and high operations should be done only for some special indication.

5. Non-febrile convalescence and freedom from local discomfort in cases in which the parturient canal is intact; it is of the greatest importance in the management of normal cases to acquire skill in so guiding the passage of the head and shoulders over the perinæum that the risk of even a slight laceration may be reduced to a minimum. In addition to the danger of a mild puerperal fever, lacerations have a tendency to interfere with the involution of the vagina and uterus, and they predispose to many conditions requiring treatment by a gynecologist.—*N. Y. Med. Jour.*

Herbert P. Leopold, M.D.

THE VARIETIES OF PUERPERAL SEPSIS.—Lyle considers puerperal sepsis as nothing more or less than a surgical fever arising from the infection of a wound, the only differences being :

- (1) The large extent of surface liable to infection ;
- (2) The structures involved ;
- (3) The presence of a quantity of dead material which easily lends itself to infection ; and
- (4) The fact that the patient is undergoing certain physiologic changes, which, perhaps, render her more liable to infection.

The varieties of puerperal sepsis are :

1. Sæpemia, or septic intoxication due to acute sepsis, which includes fetid sæpemia due to the absorption of the products of decomposition ; supplicative, due to the absorption of toxins produced by suppuration ; and inflammatory, due to an acute inflammation of vagina, uterus and parametrium.

2. Septicæmia, an acute septic infection which is extremely fatal, but comparatively rare, and may arise independently or as a consequence of any of the preceding conditions.

3. Pyæmia, which is due to the absorption of a septic thrombosis in one of the uterine sinuses into the blood-stream by means of the veins.

F. Mortimer Lawrence, M.D.

CANCER OF THE UTERUS AND ITS TREATMENT.—R. Sutton expressed the opinion that treatment for existing cancer of the uterus had probably reached its complete evolution. In view of the ultimate results of this treatment, which he heartily endorsed because there is none other known to take its place, he asks the question, *cui bono* ?

In discussing prophylaxis, he showed that the average age of his patients operated upon was forty-three years and a fraction, and claimed that if these patients had all been subjected to total vaginal extirpation, at the average age of forty years, that all of them would have escaped cancer of the uterus. That according to his own statistics but four per cent. of the cases would have died. Whereas nearly one hundred per cent. of the cases did die, within a period of two or three years, after operations for cancer.

He urged greater attention to the early repair of lacerations of the cervix, and a more painstaking observation and consideration, by physicians at large, of the train of symptoms preceding and leading up to the development of cancer of the uterus. He unequivocally recommends radical surgical treatment in all such cases, and clearly announces that if we are to diminish the number of uterine cancer cases, and consequent mortality, in the future, it must be done in forestalling the disease.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

ASPIDOSPERMINE AND OTHER REMEDIES FOR BRONCHIAL ASTHMA.—Halbert relates the history of a case of bronchial asthma in which dyspnoea was associated with some functional heart disturbance, some enlargement, particularly of the right side, a slight mitral murmur and evidence of emphysema. The treatment was unsatisfactory; he followed indications of all kinds, but could get no relief. Recently he has given aspidospermine 3x from no definite indication, but with marked benefit to the patient.

Of remedies to be considered in connection with cases of this kind, he mentions valerianate of ammonia as being very useful in conditions of neurotic irritation; under such circumstances it readily overcomes the spasmodic contractions of the bronchioles. Hyoscyamus and hyoscyne hydrobromate act more on the cerebro-spinal system; hence the brain and nervous symptoms are prominent, while the functional are mild, not persistent, and circulatory disturbances rarely go on to inflammation. With belladonna and stramonium there is decided cerebral excitement. Lobelia is no doubt the most typical asthmatic remedy, but nausea and vomiting always attend the cardinal symptoms. Grindelia robusta is also a valuable remedy, but there is always great cardiac weakness, with extreme sense of constriction, when lying on the back.—*Clinique*, October 15, 1900.

F. Mortimer Lawrence, M.D.

MILLEFOLIUM FOR PELVIC HÆMORRHAGES.—According to Horning, of Minneapolis, the strongest action of millefolium appears in the pelvic viscera, and so in symptoms and in practice we find that hematuria, metrorrhagia and menorrhagia are relieved by it. These hæmorrhages are of the moderately active variety, more so than those of hamamelis; they are lacking in the expulsive accompaniment of ipecac and without the fever and excitement of aconite. The discharges are bright and profuse. The patient exhibits indifference rather than active alarm. Aggravation of symptoms occurs through the evening and night, amelioration coming during the day. The mental and sensory conditions are relieved by vigorous exercise. If we apprehend the true spirit of the remedy, we readily appreciate how this must be true, since active exercise by increasing the activity of the general circulation will relieve a congestion due to simple inertia. We can also understand how the other aggravations occur at night; knowing that at that time the bodily functions are at a lower ebb than when under the stimulus of the day activities.

It makes but little difference, in the application of millefolium, whether we consider the head, the thoracic, abdominal or pelvic viscera, for in each and

all we find predominating all else this state of inaction, this atonic condition. The keynote of the remedy are an atonic state or constitution, and active hæmorrhage of greater or less degree.—*Minn. Hom. Mag.*, October, 1900.

QUININE IN PERIODIC FEVERS.—Wesselhoeft, in treating cases of fever returned in the Spanish war, omitted all medicine for from three to five days, studying the temperature curve until the exact type of the fever was ascertained. In some of the cases it became necessary to have the temperature taken every two or three hours. He also examined the blood for the plasmodium malariae, and found no real apyrexia except in cases where these germs were present.

In the typhoid cases he found rhus and arsenic indicated, besides belladonna, gelsemium and other remedies. In the cases of true malaria he found a small variety of remedies indicated, of which he mentions china, arsenic and nux vomica. But the china or the sulphate of quinia he found to be the most important remedy. Under this the plasmodium would disappear and all the symptoms improve. He says: "My whole method can be summed up in a few words: Find the fever-fall point and give one grain of quinine every six hours, and you will find that in a large number of cases the paroxysm will not return." He has experimented upon himself with this drug, taking a grain each night and morning, and he found no bad results from it. On the contrary, he was altogether better for it. And now he makes frequent use of this remedy in malarial cases characterized by marked apyrexia.—*New England Medical Gazette*.

F. Mortimer Lawrence, M.D.

ARGENTUM NIT. IN NERVOUS GASTRALGIA.—A case is reported for the clinic of Prof. Halbert of a man, aged 32, whose cardiacal symptoms were (1) violent belching, worse at midnight; (2) a heavy lump in the stomach, also worse at midnight. These features denoted slow digestive action. The next important symptom was pain in the epigastrium; (1) paroxysmal; (2) not relieved by pressure as in ordinary gastralgia, and (3) always associated with decided gaseous distention. He complained of muco-purulent discharges from nose and bowels, general symptoms of gastro-intestinal rotation, and a functional paraplegia already existed as a sequence of injury.

Physical examination showed a right infra-clavicular consolidation of some standing, epigastric tenderness, some gastric dilatation, general emaciation, amounting to an atrophy in the face. He was nervous, irritable and inclined to melancholia.

The case was differentiated from hyperchlorhydria, which has rapid and not tardy digestion; from digestive gastralgia caused by food disturbance; from gastritis and gastric ulcer; from carcinoma; from true gastric dilatation; and from nervous dyspepsia with changes in the secretions.

Argentum nit. was given in the third decimal attenuation, aqueous solution, five drops in water four times daily. This remedy represents (1) a neurotic history; (2) a degenerative and debilitating tendency; (3) paroxysmal and periodic seizures irrespective of food; (4) violent belchings, worse at night; (5) paralytic weakness; (6) undue discharge of motor nerve force from nerve degeneration. Gelsemium, a remedy considered, implies more congestion, and irregular, not degenerative, motor paralysis. Then, too, with gelsemium the attacks are sudden and more neuralgic in character. Gelsemium

has myalgic pain of the upper extremity; there is rarely any stomach disturbance, and no periodicity.

Under argenteum nit. paraplegia and gastralgia both entirely disappeared.—*Clinique*, October 15, 1900.

F. Mortimer Lawrence, M.D.

ARSENIC IN SKIN DISEASES.—Collins, of Chicago, states that arsenicum is no more a "cure-all" for skin diseases than bryonia is for rheumatism, and this valuable remedy is too often expected to cure a case simply because it is known in a general way to be a good remedy for eczema. As a matter of fact, arsenic covers only a comparatively narrow sphere of skin symptoms, and these lie mostly in the following characteristics, viz.: arsenicum acts first of all upon the cerebro-spinal nervous system as an irritant, soon to be followed by a paralytic effect; especially is this true of the gray matter of the cord in vaso-motor paralysis. On account of this depressing effect on the nervous system, the circulatory system is likewise depressed and retarded, and it is here that we get our first hint as to the remedy from the appearance of the skin. The latter is pale, waxy, with ecchymosed-looking spots; pale blue skin, with blue lips and blue nails, with a tendency to œdema. This is the venous stasis of a weakened circulation.

The next consequence will be a dry skin, an inactive skin, a skin that is deficient in its nutrition. A skin that is defective in nutrition must necessarily tend toward necrosis, therefore we see the arsenicum patient constantly throwing off quantities of dry epithelial cells. Necrosis of tissue may occur also: gangrenous ulcerations, with blue margins and foul discharges.

Acne vulgaris in people of a lowered vitality with many comedones and pustules, showing the sluggish nature of the case, œdema about the eyes and purplish zones about the acne papules, point to a vaso-motor paralysis. Arsenic is more often useful in the chronic, latent, dry, indolent and scaly stages of disease than in the acute, inflammatory, moist or bullous. It is most often called for in dry eczema, subacute acne, seborrhœa sicca, ichthyosis, varicosis and psoriasis.—*Clinique*, October 15, 1900.

F. Mortimer Lawrence, M.D.

CRATEGUS AS A HEART REMEDY.—Halbert, of Chicago, records a case of aortic regurgitation with compensatory failure in which crategus, five drops of the tincture four times daily, occasioned remarkable improvement. Except for an occasional attack of angina, for which he needed other remedies—generally spigelia—the patient received no other medicine. We have heard much of crategus, but as yet no definite provings have been made. Halbert regards it as a most valuable remedy. Its sphere of action, in accordance with his experience, is mostly where compensation has failed, and then it should be used until there are positive signs of improvement in this respect. Any persistent cardialgia, dyspnœa, or other unfavorable symptoms should indicate its suspension for a time, as with any other remedy.—*Clinique*, October 15, 1900.

THE ETIOLOGY OF RHEUMATIC FEVER.—Poynton and Paine (*Lancet*, September 29, 1900) have demonstrated diplococci in eight successive cases of acute rheumatism; and in five cases they were present in pure culture. They have obtained them (a) from the blood of living patients suffering from acute rheumatic pericarditis; (b) from the pericardial fluid and from granulations

removed from the valves after death; and (c) from the throat of the living patient suffering from rheumatic tonsillitis. They have been demonstrated in the cardiac valves, pericardium and tonsils, and in a nodule, in fatal cases of rheumatism. They have isolated them and grown them in an acid medium and upon blood agar; and also in the pericardial fluid, which proved to be acid in such cases. The organisms have been isolated in pure culture from the joint exudation, heart blood, bladder urine and cerebro spinal fluid of inoculated rabbits; and they have been demonstrated in the cardiac valves, pericardium, joint exudation, kidneys, liver, connective tissues, pleura, cerebro-spinal fluid, lungs and urine of rabbits inoculated intravenously. They have also been demonstrated in the perivascular lymph spaces of the pia mater, in its capillaries, in some parts of the motor area of the brain, and in the mitral valves, in cases of chorea.

When inoculated intravenously into rabbits they produce a polyarthritis, a bursitis, and a tenosynovitis. This polyarthritis may disappear completely. In some joints that have been affected for a considerable time the fluid is opaque, in others clear. They produce valvulitis and pericarditis, both non-suppurative; and in addition a coagulation-necrosis in liver and kidneys, the convoluted tubules of the latter being affected; plastic pleurisy; and pneumonia. Moreover, they produce a fatty degeneration and destruction of the myocardium analogous to the rheumatic carditis of a human heart.

The clinical symptoms include multiple painful joint swellings, moderate pyrexia, together with such heart phenomena as tachycardia, dyspnœa, irregularity, valvular murmurs, and pericardial friction.

These organisms occur as minute cocci associated in pairs; in liquid media they grow in chains of varying length, while in solid media they grow in masses like staphylococci. There can be little doubt that they are identical with the diplococci discovered by Triboulet in 1897, and by Wasserman in 1899. Their discovery in the rheumatic nodule is of especial interest, for this lesion is highly characteristic of rheumatic fever.

F. Mortimer Lawrence, M.D.

THE PATHOGENESIS OF GOUT.—Gore (*Brit. Med. Journal*, September 29, 1900) claims (1) that gout is not due to the presence of uric acid in the blood; (2) that the symptoms of gout are due to a toxin; (3) that the concurrent presence of uric acid is due to the action of the toxin on the liver; and (4) that the toxin is formed by the action of one of the intestinal bacilli on an intestinal secretion specifically altered by diet, this alteration being assisted by hereditary disposition.

Flager (*Münch. Med. Woch.*, August 7, 1900) also rejects the old view that the essential element of gout is the deposit of uric acid in the joints, and believes that this deposit is only a symptom, as is also the increase of uric acid in the blood. The deposit occurs in the joints secondarily to a necrosis in the joint tissues, the latter being brought about by the irritating action of certain alloxur compounds, particularly adenin, circulating in the blood. It has been shown that before the outbreak of gout there is a retention of nitrogen in the system which is not accompanied by an increase of weight, and is to be credited to the presence of nitrogenous extractives of the alloxur or uric acid group. Of these adenin is the most harmful, producing necrosis with extensive disintegration of the tissue-cells, and the decomposing nucleins of the latter lead to an accumulation of alloxur bases and uric acid in the blood. The uric acid thus produced, or that existing preformed in the blood, is de-

posited in the affected parts as tophi. The recent theory of Luff, according to which the primary fault is in the kidneys, is rejected by this author.

F. Mortimer Lawrence, M.D.

THE EFFECT OF INFLUENZA ON THE NERVOUS SYSTEM.—Bury, opening the discussion in the section of medicine of the British Medical Association, stated that cases in which the nervous system seems to be especially selected for attack by the influenza bacillus and its poisonous products may be divided into two groups:

1. A group of nervous diseases which develop during or shortly after the febrile stage, such as meningitis and hæmorrhagic encephalitis.
2. A group of nervous diseases which usually occur after the attack has subsided, such as neurasthenia and multiple neuritis.

Of the nervous diseases belonging to the first group, two types of cases may be seen: (1) The comatose type and (2) the delirious type. In the comatose type the patient gradually becomes drowsy and apathetic; recovery may ensue, but a fatal termination is more common. Examination of the brain may reveal nothing abnormal, or there may be congestion of its surface, or purulent meningitis with or without an encephalitis, which is usually hæmorrhagic. In the delirious type, restlessness, irritability, delirium and even mania may occur. As a rule, affections of the cord develop after the attack; but in rare cases spinal symptoms show themselves during the attack, and may constitute its salient features.

A greater variety of nervous disorders follow influenza than any other disease. Post-influenzal paralyses must be either functional disturbances by the toxins, or very slight changes in nerve tissue, inflammatory or degenerative in character.—*Brit. Med. Journal*, September 29, 1900.

F. Mortimer Lawrence, M.D.

SUPRARENAL EXTRACT AS A HEART TONIC.—Floersheim states that when the heart has been irregular in its rhythm, with lessened force and quality of sounds, suprarenal capsule has caused it to become more regular, the force being markedly increased and the pulse stronger. In some cases a slight increase in the number of beats was noted, while in other cases no change or even slight decrease ensued. When the heart action was full, bounding and regular, no effect was noticed; but when it was flaccid, the pulse weak, the apex beat diffused, the action fluttering and irregular, marked and beneficial results followed the use of the drug. After the immediate stimulating effects of the latter have passed off the heart seems to be left in better condition than before. Sometimes suprarenal causes the intermittency to disappear. The extract acts in from ten seconds to ten minutes.—*N. Y. Med. Jour.*, October 6, 1900.

F. Mortimer Lawrence, M.D.

VARICES AND VARICOSE ULCERS.—Dr. Richard Haehl considers pulsatilla the remedy to be preferred to all others. It is indicated by the pain and swelling of the leg and the bluish discoloration of the skin. Arsenicum corresponds to a similar state, but there is with it a tendency to burning. He would think of hamamelis when there is a tendency to hæmorrhages. Rhus tox., silica, secale and lach. may also be indicated. Massage at first, carefully done, of the neighborhood of the ulcer, is a valuable adjuvant.—*Homœopathische Monatsblätter*, No. 9, 1900.

Frank H. Pritchard, M.D.

TREATMENT OF HYPERTROPHY OF THE PROSTATE.—Dr. Dudley Wright in managing this disease with its attendant consequences, advises to urinate as soon as the desire is experienced, to avoid sudden suppression of perspiration, to use fermented beverages but moderately, to beware of constipation and to have the urine examined frequently, for if it become fetid and alkaline to have recourse to the catheter.

The most serviceable remedies are : acid. picricum, ferrum picricum, mercurius, arnica, and triticum repens.

Acidum picricum and *ferrum picricum* are very useful when there is frequent desire to urinate at night in the beginning of the disease.

Mercurius is indicated when there are rectal symptoms, with constipation, tenesmus and irritation of the rectum, as well as venous congestion.

Arnica is of service when there is a great deal of irritation in the urethra and tenesmus of the bladder.

The catheter should be used daily when the urine contains a great deal of sediment and has an ammoniacal odor.—*Journal Belge d'Homœopathie*, vol. vii., No. 2.

Frank H. Pritchard, M.D.

KREASOTUM IN THE TREATMENT OF CANCER OF THE STOMACH.—Dr. Lambrechts, of Antwerp, relates two interesting cases of cancer of the stomach where there was obstinate vomiting of a blackish, "coffee-grounds"-like substance, with great emaciation, weakness general, pale, emaciated and yellowish face, the eyes sunken and hollow, the pulse rapid and feeble, the tongue coated white and dry, with œdema about the ankles. Kreas. 3x was administered, at first every two hours, in a little water. The vomiting, which had become incoercible, was soon relieved, so that a few teaspoonfuls of milk could be retained, and gradually there was such an improvement that in ten days it had nearly wholly ceased, and on the fifteenth day the malignant neoplasm itself was treated by such remedies as phos., condurango, ars. hydras. and nux. Curiously enough, though a hard and nodular growth could be made out on the anterior surface of the stomach, and the diagnosis was confirmed by a professor of a Belgian university, she lived for nine years after, and died suddenly during an attack of vomiting which was uncontrollable by any means. A similar case was controlled by kreasotum, and the patient lived for four years after. Though not a curative, the drug is of value as a palliative in these unfortunate cases.—*Journal Belge d'Homœopathie*, No. 3, 1900. (Gœdke, *Practice of Medicine*, vol. ii., speaks of such cases where the cancer of the stomach appears to undergo atrophy.)

Frank H. Pritchard, M.D.

KREASOTUM IN VOMITING FROM DILATED STOMACH.—Dr. Bourzutschky was consulted by a woman who for four years had been in the habit of vomiting every day. About four hours after eating she would suddenly eject about a quart of a brownish substance. The long retention of food before vomiting, and its undigested condition, led to a diagnosis of dilated stomach. At the same time the patient was found to be suffering from a floating kidney, which is frequently associated with this condition of the stomach. Dry diet, with as little fluid as possible, was advised, and kreasotum 4x was given four times a day on account of the keynote—vomiting of undigested food some hours after having eaten. At the same time cold compresses were applied over the stomach. A month later he heard that the vomiting had ceased two days after having commenced taking the remedy, and that improvement had been continuous.—*Homœopathische Monatsblätter*, No. 9, 1900.

Frank H. Pritchard, M.D.

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